State of Maryland / Department of Health and Mental Hygiene 2009

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 8:14 PMM Smith 2009 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSpital Baltimore Mar bor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 2,1925 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Min. 218-22-4388 84 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Expression once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director Maryland 1 Maryland Anne Arundel Curtis Bay 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21226 U.S.A. 407 Carvel Beach Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Continental Can Co. Factory Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Smith Cottrill Samue1 ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8406 Cove Road Dundalk, Maryland 21222 Sidney H. Smith, Jr. (Son) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory 08/03/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** B: lateral /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown icate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has funeral director, page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ☑ Natural
2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Helml. RSS001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore South Hanover St 3001 Vila Heersink 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 AUG 05 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician Month Carol Jean Smith 7:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** North West Hospital Hospice Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 T 218-90-6524 45 Dec. 10, 1963 Director Maryland 1 4 1 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventher must be notified at once. 10a. State 10b. County MD Queen Anne Chester 1 ☐Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 212 Dominion Road Unit 3 21619 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 2 👿 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: Specify. White 2 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager 12 Grocery Store 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Mauler, Sr. Margaret Pinder 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Mauler mother 229 Perry Corner Road Grasonville, Maryland 21638 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Bayview Crematory Aug. 4, 2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licensee 3204 Mountain Road Pasadena, Maryland 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): ) /Medical **Examiner** ROITS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 4) Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **X**No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3 2001 H48931

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

05

Baltmone MD

Smith

who completed cause of death (Item 23a) (Type, Print)

2835

amend #29a Per FH G894 8/05/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUĞÜST 2009 **BETTY** SAPOL SKY 6:52 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕽 F 202-12-9542 Director 87 02/02/1922 PΑ Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2X No Director PA ALLEGHENY **PITTSBURGH** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1420 CENTRE AVENUE #1909 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ADMINISTRATIVE ASSISTANT CITY OF PITTSBURGH 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be LEO PEARLMAN ANNA ဂ WOLFF 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS SAPOLSKY / SON 8400 PRAIRIE ROSE PLACE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place)
BETH SHALOM 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 N Removal from State 08/04/2009 SHALER TOWNSHIP, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature/of Funeral Service Licenses 8900 REISTERSTOWN RD., PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications of lung months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 KNo 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 10501 Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier TECCHTIFying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

X CNP and manner stated. CERTIFYING NUCSE PLACTIONES. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Towson, mp 21204 R 149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charly 6701 North ST 200 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20c Per Ftl. G894 8/05/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Shumin Year Physician Month August 0430 AM lava 03 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Hospice Seasons If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/25/1944 9. Birthplace (State or Foreign Social Security Number Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) Funeral Days Hours SIBERIA 213-35-1157 65 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ntal Hygiene. cd other than "natural", or Items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 💢 No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2905 LIGHTFOOT DRIVE 21209 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No WHITE Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **FACTORY** permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other thany injury or other traumatic event, the ODE. LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MORDECHAI BEAR SHUMYACHKIN RACHEL ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLA SHUMIN / WIFE 2905 LIGHTFOOT DRIVE, BALTIMORE, MD 21209 20a. Method of Disposition

1 ▲ Buri 1 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date tion 5 ☐ Other (Specify) BALTIMORE HEBREW 08/04/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. of Funeral Service License 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Pan 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic adenocarcinoma years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the death certificate be executed signed by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: for use If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death

9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Ulnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, lan 1 Tes 2 No 3 Probably 4 Unknown accillen Completed To the Hospital or Attending Physician: The law requivithin 24 hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐Yes 2 No 25. Was case referred to medical examiner? Inpatient hispice Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D35844 MI 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Roggen 5400 Old Court Rose 21133 Old Court Road 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar Barker

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Year Joan Eleanor Trump AUG 2009 44 AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death agnes Nos MON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, You July 20, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday Year) 1938 Pennsylvania Months Days 205-30-4439 1 □ M 2 🕅 F 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21228 615 Woodsdale Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 TxtNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) School System Instructional Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vera Elinor Dewald John Bernard Behler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Woodsdale Road; Catonsville, MD 21228 David A. Trump Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/8/2009 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign were Funeral Fervice 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final seeks disease or condition resulting in death) SEPSIS and Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cardiogeni 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy congestiv 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify)

Physician /Medical Examiner Examiner

be execute

P.O. Box 68760,

Division of Vital Records,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

death

filed within 72 hours after

Pages 1 and 2 should be

Maryland 21215-0036

altimore.

Director

Funeral

2

Completed

Be

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?7 is marked other than "natural", or Items 23a or 28a-f shot traumatic event, the bedical Experiment that the rotified at

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of Health and Mental Hygi item 27 is marked other

Injury or other

permit. Page Department o Important: If any Injury or once.

anding physician and use as the burial-tran atter for u signed by the a should cate has page 2 s

certificate this After or Attend after death. Director: /

completely filled in by the funeral director, within 24 hours a

Physician/Medical à Completed Be မှ Certification: Medical

State Registrar

Ke 31. Date filed (Month, Da AUG 0 Day, Year) 5 2009

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a, Certifier

4 - Homicide

(Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agnes

82. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. License number

arka

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month MOSES AUGUST 3 2009 TEITELBAUM 8:00 A /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) OLAND Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 X M 2 ☐ F 11-18-1917 **Director** 154-24-5000 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6503 PARK HEIGHTS AVENUE, #1M 21215 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 N No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2**Y** No Completed by Specify 3 X Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER GROCERY STORES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHRAGA FEIVEL TEITELBAUM CHANA 2 ROIZA ETTINGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3713 MENLO DRIVE, BALTIMORE, HANNAH KAGAN/DAUGHTER MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State MOSES MONTEFIORE 08-04-2009 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underhing Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2**X**7No Completed 1 ☐ Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \tau \) Nursing Home \( 5 \) Residence \( 6 \) Dother (Specify) \( \tau \) O \( \tau \) 2 200 ٩ 1 ☐ Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Division of Vital Records, P.O. Box 68760 certificate be Hebaum Moses within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral Hospital or Attending

28a-f show

if item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Middal Evant included to mydified at

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any Injury or other trau

physician and s the burial-transit

attending p

cate has been signed by the page 2 should be detached

this certificate

Baltimore, Maryland 21215-0036

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State Registrar

(Check only one

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year, August

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles ST

Year) 32. Registrar's Signature AIIG 05 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Ivan C. Vickers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Washington Co. Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 18 M 2□ F Days Min 73 298.30.5937 06.15.1936 OH Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in "Nacieal Examine must be natified as my injury or other traumatic event, in "Nacieal Examine must be natified as 1 ☐ Yes 2 ☐ No Director MD Washington Hagerstown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 750 Dual Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Stes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Antiques Sole Propietor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olga Elizabeth Schaer Vickers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3629 Sussex Rd. Gwynn Oak, MD 21207 19a, Informant's Name/Relationship (Type, Print) Joan Gebhardt/Cousin Pages 1 g 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State 08.06.09 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. Lohrmann PA 21. Signature of Funeral Service Licensee MO 1443 8717 Green Pastures Dr. Baltimore, MD Approximate Interval Between Onset,and Death 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a conse to nce of): **Physician** nuny disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of sician and burial-trans Exam P.O. Box 687605 Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar

AUG 0 5 2009

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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de l'All		VOII201144 BOILLE   VIII   VII	nty of Death
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Funeral			YYY) 9. Birthplace (State or Foreign
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ath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. R. W	ace - American Indian, Black, Vhite, etc.
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Baltimore, permit. Pages I an Department of Hee Important: If ite	1	20b. Place of Disposition (Name of cemetery, Cremation 3 Removal from State 4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, Crematory or other place)  A Donation 5 Other Specify:  21 Signature of Funeral Service Lickinsee  22. Name and Address of Facility The DERRICK  4 Service Lickinsee	C. JONES FIH.P.A
iii E P P R		23a. Part I. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or	Le MARILAND
Physician		23a. Part I. Enter the disease, or complication afrat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.	r heart Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease a Multiple Gunshot Wounds	Death
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Box 68760, e death certificate be the attending physicied for use as the bun	Sici	4 Pregnant at time of death 5 Other (Specify)	
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Division of Vital Records, P.O. Hal or Atteoding Physician: The law requires that the staff cleath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ð	1 Yes 2 ✓ No	3 Probably 4 Unknown
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attreading Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn			
To th within To th	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.	
	2		signed (Month, Day, Year)
		Carol Heller O.C.M.E. July 30,	2009
		30. Name and address of person who completed cause of death (Item 23a)  Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
St	ate		
Regist	rar	ACIA DE TIMO (A	

Registrar

DHMH 17 Rev 1/2001

State

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32. Registrar's Signature

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31. Date\_filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Dea Examiner xalt Imor Haven Nursing atonsville Home Social Security Number 6. Sex 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2 🗗 Director 950RG11 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ any injury or other traumatic event. Black, White, etc. 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: 2. No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Be 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses Name and Address of Facility 23a. Part 1 briter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** asmar ementi. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 45 Mursing Home 2 40 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation To the Hospital or Attending 1 Natural
2 Accident Injury 1 Tes 2 No Director: / 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Direct completely filled in by 1 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D4768 / Vary 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Maymore Miller Renjestown Street Soute

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State Registrar Date filed (Month, Day, Year)

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ry Walls		1- For State	ate of Maryl		artment of rtificate of			Menta	al Hy		Reg. No.	20	09	2501
Physicia edical Examin	an/	Registrar  1. Decedent's Name (First, Midd		+1	C	LIo 11			1	Date of Dea Month August 2	ath Day	Year		3. Time of Death 2015 hrs
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) Funeral		Gilchrist Hospice  5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Towso		If Under	24Hrs.	8 Date of B		Baltimore		place (State or
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ore, Nest and of Health If item		20a. Method of Disposition  1 X Burial 2 Cremation		20b.	Place of Disposit crematory or other		of ceme	etery,		Date	20c.	Location - C	ity or T	own, State
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Box 6876 edeath certificate the attending phy	Physician/M	past 12 months?	4 Preg	nant at time of de	nath -	al death er <i>(Specii</i>	3 <u> </u>	Ectopic	pregnan	cy 		Month	Da	ay Year
the dear	Phys	Part II. Other significant condit	ions contributing		resulting in the ur	derlying (	ause niv	en in Part		23e. Did	tobacco	use contrib	ite to th	ne cause of death?
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of Vital Records, g Physician: The law require this certificate has been sineral director, page 2 should b	Completed	_								24a. Was				opsy findings available impletion of cause of
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		Russell Alexander MD	). Assistant	Medical Exar	miner 111	Penn S	treet, E	Baltimor	e, MD	21201				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Ye ar 40 PM **Physician** HEEN AUGUSI 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTI MORE SECOURS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🛂 Hours 22434 1157 Usual Residence of Decedent 7-25-1929 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, Ire Medical Evaniner must be notified at 1 Yes 2 □ No Director Hmore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 0122 454 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and 2 should be file.
...and 2 should be file.
...mortant: If item 27 is mark...
ny hiury or other... 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) nKnown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 W. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter 1 ■Burial 2 Cremation 3 Removal from State Park Cemetery 8-8-09 Woodlawn MD 22. Name and Address of acility Vaughn C. Greene French Larvice 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ba 1 to MA 21229 Honore Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOVAS CULAR DISEASE **Physician** disease or condition resulting in death) /Medical Examiner 120 Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner MONAR law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown ò signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 1 □Yes 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 →No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner I reath Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The of Vital Division 24 hours after death. Funeral Director: stely filled in by the completely To the I To the

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

32. Registrar's Signatur

00030355

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOX SECOURS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>009 July 19, 1:43 P **Physician** Nancy Susan APPEL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Jan. 13, 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 ¥ F 1966 Washington, DC 43 212-64-1394 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Michal Examina must be notified at 1 ☐ Yes 2 No N. Bethesda Montgomery Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20852 5801 Nicholson Lane #632 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2∭No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Hygiene. College (1-4or 5+) 5+ Elementary/Secondary (0-12) Assistant State's Attorney Government h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phyllis Ackerman Leonard Appel ೭ 19b. Mailing Address (Street and Number or Pural Route Number, City or Town, State, Zip Code) 16320 Bawtry Court, Bowie, MD 20715 19a. Informant's Name/Relationship (Type. Print) iand 2 s Health a 16320 Bawtry Court, Bowie, MD Phyllis Appel, Mother permit. Pages 1 and Department of Healt Important: If item 27 any injury or other tra once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 07/22/09 Adelphi, MD 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licensee ชื่อพิธีกับที่รั้ง ที่อียีพ้อพ Funeral Home M01008 20012 254 Carroll St., NW. Washington, DC Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 Days Physician Complications of Seizure Disorder /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to lor as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Hospital or Attending Physician: The 2 **☑**No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1X Yes 2 □ No Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation e Funeral Director: Aft letely filled in by the fun 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. To the I within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D37840 20,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Brent A. Berger, M.D., 10215 Fernwood Road, Suite 100A, Bethesda, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Back 22 JUL Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Dav **Physician**  $P^{\mathsf{M}}$ Stanley Marshall Ansel July 2009 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crownsville Anne Arundel 1169 Bacon Ridge Road If Under 1 Year | If Under 24 Hrs. | 8. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) Days Hours Months 1 🔀 M 2 🗆 F Yrs. 94 2/18/1915 Pennsylvania 168-05-3518 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑No Director Crownsville MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1169 Bacon Ridge Road 21032 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 □ No If Yes, Give Year or Dates1 942–45 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Westinghouse 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luther Ansel Anna Nellie Burke ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther A. Dawson/Daughter 1169 Bacon Ridge Rd., Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 7/22/2009 Crownsville, Maryland 5 ☐ Other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CD 922 Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Dav 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 1 No 1 □Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one DAVOITIES Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ Home 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed and burial-trar attending physician for use as the buria signed by the a d be detached f peen has certificate Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

**Funeral** 

Director

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r than "natural", or items 23a or 28a-f shov

death with the Maryland

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any Injury or other traumatic event, train any Injury or other traumatic event, trains any Injury or other traumatic event, trains any Injury or other traumatic event, trains any Injury or other traumatic event, trains

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

within 2 State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

Ectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

e and address of person who completed cause of death (Item 23a) (Type, Print 50

31. Date filed (Month, Day, 2009

29a, Certifie

Medical

32. Redistrar's Signature

09-05826 Jose Acuna Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she other transmatic event, the Medical Examiner must be notified at once	Be	Armando Carba 19a. Informant's Name/Relation			19b. Mailin	g Address	Street	and Number	or Rural Route N	umber,	City or Tow	n, State	e, Zip Code)
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Ba Pern Dep Imp	$\Lambda$	Places &	may C	COQ	5/3	447 14	th	St. N.	W. Wash	ing	ton, D	C 2	0010 • Approximate Interval
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DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 29 2009 9:30 A. M July /Medical Annabelle Marie Anderson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours Min. 09/17/1929 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F 215-26-7991 79 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 1 XYes 2 No MD Frederick Director Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 320 Redwood Ave. 21701 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify. Specify: White 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly line factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Franklin Harne Eva Elizabeth Harshman 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Anderson / son 5516 Woodlyn Rd., Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 8/1/2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service License Janualle three MO1222 106 E. Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to innediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 40 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 D.No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospina.
within 24 hours are death.
To the Funeral Director Aftr 1 Waturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined

P.O. Box 68760, or Vital Records, ral", or Items 23a or 28a-f sh Examiner must be notified ≀

3altimore, Maryland 21215-0036

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signed by the attending physician be detached for use as the buria

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nysician as;

elCenaun Registrar

State

Medical

29a. Certifier

29b. Signature and title of certifier

29c. License number

30. Name and address of person who completed

05

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001

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	Physicia	an	1. Decedent's Name (First, Middle, Last)  Brian Dean B	radbury	7		2. Date of Deal Month	Day Year	M. M.
	/Medic Examin		4a. Facility Name (If not institution, give street and number)			r Location of Death	July	16 2009 4c. County of De	ath
· ·			Bome Health Can	ter		13000°		Prince	
	Funeral Director		5. Social Securify Number 6. Sex 7. Age (In yrs 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	9. B 13 1964	rthplace (State or Foreign Country) WashingtonD(
	and 1		Usual Residence of Decedent           10a. State         10b. County         10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	Mary a-f sho	to	Maryland Prince Georges Bo	wie					1. Yes 2 No
	ith the	Directo	10e. Street and Number 2800 Nestor Ct.		10f. Zip Code	20716	1	0g. Citizen of What C	country?
	eath v	Funeral	11. Marital Status 12. Was Decedent Ever in U	IS 13 V			pecify Yes or No-	14. Race - An	nerican Indian.
920	should be filed within 72 hours after death with the Maryland od Mental Hygiene. marked other than "natural" or items 23a or 28a-f show matic event, the Medical Examination nutility of in- matic event, the Medical Examination of the conflict of	by Fun	1 Newer Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced Year or Dates:		fYes, specify Cuba 1 □Yes 2 No	dispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)	Black, Wh	
2-0	72 hou natura iical E	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup	pation during most of wor	kina ı	16b. Kind of Busines	s/Industry
Maryland 21215-0036	vithin sne. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		00 NOT use retired al Stude	during most of word)	9	U. S. Air	Force
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/lan	12 should be f h and Mental 7 <b>Is marked o</b> traumatic eve	To B	Reginald Dean Bradbury			Phyll <b>i</b> s	(Miller)	) Bradbury	
Mar	ar sa		19a. Informant's Name/Relationship (Type. Print) Phyllis Bradbury Mother		•			r, City or Town, State	Zip Code)
	1 and Health tem 27 other tr		20a. Method of Disposition 20b.		NESTOR C sition (Name of natory or other place	t. Bowie	Date	20c. Location - City of	r Town, State
Ē	Pages nent of int: if it iry or o				crematory or other place.	y 7/20	7/2009 (	Glen Burni	e, Md.
Baltimore,	permit. Page Department o important: if any injury or once.		21. Signature of Funeral Service Licensee  M005		Name and Addre	ess of Facility Annapol:			uneral Home 20715
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	19in	5				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a conse	quence of):					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):					
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90	tificate be executed g physician and as the burial-transit	al E)	resulting in death) Last Due to (or as a conse	quence of):					
68/60	tificate g phys as the	edical	d			,			
		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregration in the past 12 months?		Ectopic pregnanc	;y		23d. Date of d	elivery Day Year
5	he dez the a	ysici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown	death 5□	Other (specify) _			WOTH	Day Teal
τ.	law requires that the death cel as been signed by the attendir 2 should be detached for use	by Ph	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?
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Š	~ = 70	Completed					24a. Was a	an 24b. Were prior to	autopsy findings available completion of cause of
i			OF Western day and day					2-2 No 1 □ Ye	es 2 No
VITa:	ysicia s certi directo	To Be	25. Was case referred to medical examiner?  1☐ Yes 2☐ No  Hospital: 1☐ Inpatient 2☐	TER/Outpatien	nt 3 🗆 DOA Oth	ori	th (Check only or	ne) ence 6	necify)
0	Attending Physician: r death. sctor: After this certifice by the funeral director, f	J:UC	27. Manner of Death 28a. Date of Injury	28b. Time of	28c. Injur	ry at	28d. Describe h	ow injury occurred	
SIO	death. ctor: A y the fu	catic	2 Accident investigation 0//16/2009	3:/5 8	M 1 1	Yes 2 ☐ No	hims	•	0
	- = = -	Certification:	4 Homicide determined 28e. Place of Injury - At 1 building, etc. (Spec		eet, factory, office		281. Location (S City or Tow	treet and Number or n, State) 2 foc	Rural Houte Number,
	lo the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier  (Check only (Check only 1   Medical Examiner: On the basis of examiner)	owledge, death	n occurred at the ti		e, and due to the	cause(s) and man	
	thin 2 the Pomplet	Med	one) and manner stated.  29b. Signature and title of certifier		29c. Licens	se number		29d. Date signed (Mo	nth. Dav. Year)
<b>,</b>	× × × ×		1 Alada Marto	02	100	05397	-7	Tul 18	2009
<i>-</i>			30. Name and address of person who come eted cause of death (Ite		. /			7,7	0
OF	14014		Salvador Sy/rester 300		sital.	Ori ve,	Chave	dy M	anyland
	Sta	te	31. Date filed (Month, Day, Yeaf) 32. Registrar's Sign	ature /				U	,

DHMH 17 Rev 1/2001

# 28A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1<sup>Day</sup> **Physician** 2009 10:03 A M David Lyle Brittingham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 1514 Riverside Dr. Apt. 124 Salisbury If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 10/5/1945 **Funeral** Days Hours 1 💢 M 2 🗆 F MD 63 219-42-8788 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner rules be notified at 1 ☐ Yes 2X ☐ No Director MD Wicomico Salsibury within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21801 1514 Riverside Dr., Apt. 124 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces 1 XYes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Ś Specify: white 3 Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed)  $\stackrel{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) filed withir Hygiene. Chef Restaurant 12 should be filed with and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Cropper John W. Brittingham 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) is 1 and 2 s of Health ar item 27 is 323 Park Ave, First Floor, Salsibury, MD 21801 Betty Brittingham / sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/21/2009 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Foneral Service Licensee 108 William St., Berlin, MD 21811 23a. Part1. Inter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical for use as the IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>≽</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 buours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 sompletely filled in by the funeral director, page 2 s autopsy performed? 1 □ Yes 2 🖸 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and tit 29c. License number 7/4/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day,

DME

100 E Carroll

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Vantage House Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 095-09-7993 96 06/08/1913 Director NY Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits fshow ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director MD Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? with 21043 United States 8234 Academy Road by Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S.
Armed Forces? 19431 Yes 2 No 1045 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify 1945 Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Elias Gustav Bory 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8234 Academy Road Ellicott City, MD 21043 Lynn Egan – daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 □Crem 3 Removal from State St. John's Cem. 07/23/2009 Ellicott City, MD 4 □ Donation 5 □ Other (Specif 21. Signature of Fundal Sen M01411 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 low 23a. Part1. Enter the disease shock, or heart failure. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. List only one cause on each line. Immediate Cause (Final Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed as the burial-transit and P.O. Box 68760. attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy jo in the past 12 months? Month Day Year signed by the at d be detached for 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Donknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available 24a. Was an has prior to completion of death?
1 ☐ Yes 2 ☐ No autopsy perform To the Hospital or Attending Physiclan: The within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in by the funeral director, page Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) anta Other: 4 Nursing Home 5 Residence 6 Detner (Specify, 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical

State Registrar

29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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		State of Maryland / Department of 1 - State Registrar  State of Maryland / Department of Certificate of Certi			ene 1.No. 2000 25020
Physic /Med		Leorge L. Rell ir.		2. Date of Death Month July	Day 18 2009 9:00a M
Exami		4a. Facility Name (If not institution, give street and number)  4b. City, Town,  5607 Honeysuckle Court  Fr	or Location of Death		4c. County of Death Frederick
Funeral Director		5. Social Security Number  6. Sex  1 M 2 F  7. Age (In yrs. last birthday)  Yrs.  1 Very Months  1 Day  1 Very Months  1 Very		8. Date of Birth (Month, Day, ) July 10,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Evanmer must be notified at any order.	To Be Completed by Funeral Director	10a. State   10b. County   10c. City, Town or Location	thispanic Origin? (Suban, Mexican, Puerto Specify:  supation the during most of worked)  Manager  18. Mother's Nam  Thuryle  et and Number or Rute  tlace)	pecify Yes or No- o Rican, etc.)  king  Fr ne (First, Middle, Ma Stine ural Route Number, of ddletown, Date  20	a. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: White  6b. Kind of Business/Industry  Cederick Keys Baseball aiden Surname)  City or Town, State, Zip Code)  Maryland 21769  Oc. Location - City or Town, State  Keedysville, Maryland
icate be executed Tay Demrit.  physician and Tay Depart  physician and Depart  stree burial-transit Depart  properties of the purial-transit Department D		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	dress of Facility Funeral Ho sumtown Pi lying, such as cardiac	ke, Frede	erick, Maryland 21702
ecords, P.O. Box 6  w requires that the death certif s been signed by the attending s should be detached for use as	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown    Part II. Other significant conditions contributing to death but not resulting in the underlying cause of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   9   Unknown    Part II. Other significant conditions contributing to death but not resulting in the underlying cause		1 ☐ Yes 24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of
DIVISION  or Attending after death. Director: Afte	Certification: To Be	25. Was case referred to medical examiner?  1	Other:  4 Nursing Higher Address Addre	ath (Check only one) tome 5 D Residen 28d. Describe how 28f. Location (Stre- City or Town, e, and due to the cal	nce 6 □Other (Specify)  vinjury occurred  set and Number or Rural Route Number, State)  use(s) and manner as stated.
	Medical	30. Name and address of person who completed cause of dead (Item 23a) (Type, Print) William H. Convey, MD 195 Thomas Johnson Driv	anse number 20395	290	d. Date signed (Month, Pay, Year)
St Regist	ate	31. Date filed (Month, Day, Year)  32. Redistrar's Signature			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Month **Physician** asz M 14 Brown, Jr DAvid Jashua /Medical 4c. County of Peath 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Porches Dorchester General (ambridge 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 12 M 2□ F Months Days Hours 06-21-1962 **Director** 219-78-4592 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show per nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Der artment of Health and M. ntal Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any lighty or other traumati: event, it w. M. offcot Evan, is a rount by nuffic of any lighty or other traumati: event, it w. M. offcot Evan, is a rount by nuffic of any one. 1 Nes 2 No Director Md. Dorchester Hurlock 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 118 Dorchester Ave. Funeral USA 21634 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. <u>م</u> 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U S Army Veteran 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David J. Brown, Sr. ٩ Ailene Rebecca 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Dorchester Ave., Hurlock, Md. 21643 e of Disposition (Name of Date 20c. Location - City or Town, State Rosetta Brown / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cem. 07-27-09 4 Denation 5 ☐ Other (Specify) Md. Hurlock, Md. 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signaturu de la Service ricensee 516 S.Main Street, Hurlock, Md 21643 MMA 1 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final myo cordiz **Physician** disease or condition resulting in death) /Medical Examiner cretionyo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a t be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown nis certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 ⊡No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours after e Funeral Dire eletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

within 2

State Registrar 29b. Signature and title of certifier

NOMAN

31. Date filed (Month, Day,

BYRN 503 MARNEY Year) 7 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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7.16.09

CAMPRIDGE MD 2/6/3

Larry Anthony Br	O/W/L	vne State of Maryland / Department of Health and Mental H		
Larry Antilorly Bi		1- For State Continue of Department of Health and Meman	Reg. No. 200	9 2502
Physicia	_	Registrar	2. Date of Death	3. Time of Death
Medical Examir			Month Day Year July 18, 2009	2148 hrs
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		Prince Georg's Hospital center  Cheverly  5 Social Security Number  6 Sex  7 Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hr		
Funeral Director		Months Days Hours Mi	in. Cou	intry)
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any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
<u> </u>	١	Maryland Prince George's Glenarden		1 X Yes 2 No
faryla: 28a-f	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Cour	itry?
rdeath with the Maryland or items 23a or 28a-f show must be notified at once.			United State	.s
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5-0036 iled within 7/ Hygiene. I other than			ne (First, Middle, Maiden Surname)	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other trammatic event, the Medical Examiner must be notified at once	7			
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Sion Attended the control of the control of the	cati	2 Accident 5 Pending Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R	ural Route Number, City
Division of Vital Records, tal or attending Physician: The law requirers after death.  al Director: After this certificate has been sifed in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)	
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¥ 8	Me	29b. Signature and title of certifier  29c. License number	29d. Date signed (M	onth, Day, Year)
		functifall, MD O.C.M.E.	July 20, 2009	
		30. Name and ad person who completed cause of death (Item 23a)	MD 21201	
CR 10		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore 31. Date filed (Month, Day, Year) 32. Registrag's Signature	5, IVID 2 120 I	
S <sup>.</sup> Regis	tate tra			
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	1	For State Registrar		State of	Marylar		artmen rtificate					Reg. No.	009	25023
8.5	1	. Decedent's Name (First, Mi	ddle, Las	t)							2. Date of Dea Month		Year	3. Time of Death 3:06 P M
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Examiner	4	a. Facility Name (If not institu	_		iber)		2.		Location o	of Death			County of Dea	
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Funeral	5	Social Security Number	6. Se	M 2ŽF	7. Age ( <i>tn yrs.</i> 88	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Da) Sept. I	Year	920 M	thplace (State or Foreign ountry) laryland
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760, Te be executed System and Interest Examiner Cal Examiner		resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	$\left\{ \right.$	b. Due to (	(or as a conse (or as a conse (or as a conse	equence of):								
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To the within To the compl	M	29b. Signature and title of ce	rtifier	```	1		29	c. Licens	e number	,		29d. Da	ate signed (Mo	nth, Day, Year)
	<	I hay what	e M	N) De	puty		\	J 18	666	<i>'</i>		Jul	Y = 1 :	2004,
		30. Name and address of per	son who	completed cause	se of death (II	om 23a) (Type		4:11	CTL	then	ville,	MJ	2109	73
State Registra		31. Date filed (Month) Day, Y	05	2009 32. F	egistrar's Sig		park	A. C.						

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 5:15 A M 2009 July 30. AERONITA CHRISTINE BELLE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (tn yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 X F September 25, 1933 452-50-6082 75 Texas Director Usual Besidence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 Yes 2 No Director Frederick Keymar Maryland the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 21757 United States 11821 Handboard Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ∐Yes 2 No Specify. Specify: Š 3 ☐ Widowed 4 🖾 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify onty highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "I any Injury or other traumatic event, I'm Med College (1-4or 5+) Elementary/Secondary (0-12) Federal\_Government Claims Filer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aeron Douglas Belle Breaux Olga 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Nickerson / Nephew 5700 Up-A-Way Drive, Fredericksburg, Virginia 22407 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory August 1, 2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ere ho Vascular Accident Immediate Cause (Final **Physician** 0445 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for an argumenter off The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE for use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐Yes 2 No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Xnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Sign 29c. License number 00062223 Name and address of person who completed cause of death (Item 23a) (Type, Print)

PLAYE BY BOLTMUM, MD 196 TJ DUVE, PREDEUCE, MD-21 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

21/

State Registrar

DHMH 17 Rev 1/2001

DK

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

Jariwala, MD

32 Registrar's Signature

11637

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

errace Drive,

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

		-	For State	State of	Marylan		artment of F rtificate of		d Mental Hy		0 0 0 0 0 7
			Registrar  1. Decedent's Name (First, Middle, I	ant)			incate or	Death	2. Date of De	Reg. No.	3. Time of Death
	Physicia /Medic		Mary Ann	Cherry					July		ear
1	Examin		4a. Facility Name (If not institution, g	live street and nur	nber)		4b. City, Town, o	r Location of D	eath	4c. County of	
			Cherry Lane Nur	sing Cen	ter			ırel			George's
Ī	Funeral Director		5. Social Security Number 6 509–03–3060	. Sex 1 □ M 2 □ XF	7. Age <i>(In yr</i> s. 99	last birthday) Yrs.	If Under 1 Year Months Days		Ain (Month, D	rth ay, Year) 5 16,1909	Birthplace (State or Foreign Country)  Kansas
	р .		Usual Residence of Decedent		10- 0	. T					10d. Inside City Limits
	rrylar show	_	10a. State 10b. County	·	10c. CI	ty, Town or Lo	Centrevi	110			1 □Yes 2 ☑ No
	Ba-f	Director	MD Queen A	une s						10g. Citizen of Wha	et Country?
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	ath v	eral	306 Overture Wa		Hant Ever in II	6 12			? (Specify Yes or N	n- 14 Bace	American Indian,
	er de	Funeral	11. Marital Status	Armed Fo		1.5.	If Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)		White, etc.
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Everginal and by notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	ve		1 □Yes 2 No	Specify:		Specify:	White
ş	hou		15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation	· · · · · · · · · · · · ·	16b. Kind of Busin	ness/Industry
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פ	othe vent,	Be C	17. Father's Name (First, Middle, La	st)				18. Mother's	Name (First, Middle	e, Maiden Surname)	
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ar)	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Ma		19a. Informant's Name/Relationship			1				ber, City or Town, St	
Σ	and and n 27		Mary A. Lewis/Da	aughter						le, MD 216	
ore	of H	1	20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□ Removal from	State I		osition (Name of matory or other pla		Date	20c. Location - Ci	
Ĕ	Pag ment ant: I		4 Donation 5 Other (Spe		Ga		Heaven Ce		/24/2009	Silver Sp	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trae		21. Signature of Funeral Service Li	cepeee		2	Name and Address			Tuneral Ho	
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Вох	eath certific attending p	N/W	IF FEMALE: 23b. Was decedent pregnant		tcome of pregr birth 2□Fet		☐ Ectopic pregnan	icv.		23d. Date	
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<u>Р</u> О	that the de ned by the a detached f	hys	9 Unknown						OOo Die	t tabanaa uga aantrih	oute to the cause of death?
- 10	w requires that s been signed I should be det		Part II. Other significant condition Atrial Fil			sulting in the t	underlying cause g	ven in Part I.			B ☐ Probably 4 ☐ Unknown
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ŭ	ling F	io ::	27. Manner of Death 1 X Natural 5 ☐ Pending		nth, Day, Year)	Injury	Wo	ork? ⊒Yes 2∐No		e now injury occurred	u .
isi	Attending r death. ector: After by the fune	icat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be 280 Place	e of Injury - At	home, farm, si	treet, factory, office			(Street and Number	r or Rural Route Number,
Division of Vital Records	i Sir e	Certification: To	4 ☐ Homicide determin	ed build	ling, etc. (Spec	cify)				own, State)	
	ours ours ours ours ours		29a. Certifier 1 Certifying	Physician: To th	e best of my kr	nowledge, dea	ath occurred at the	time, date and	place, and due to the	he cause(s) and mar	nner as stated.
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical E	xaminer: On the	basis of examination of the stated.	nation and/or i	investigation, in my	opinion, death	occurred at the tim	e, date and place, a	nd due to the cause(s)
	To th withir To th comp	Me	29b. Signature and the of certifier	10/			29c. Licer	nse number		29d. Date signed	(Month, Day, Year)
			1 SKU/14	AX			D43	3351		7/21/:	2009
			30. Name and address of person v	no completed cau	ise of death (Ite	em 23a) (Type					
( }	生り		Dr. Ikechi Fre				œlt Rd.,	Ste. [	J-15, Coli	lege Park,	MD 20740
	St	ate	31. Date filed (Month, Day, Year)	1 2000 32.	Registrar's Sign	nature	,				

Registrar
DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death <sup>Day</sup>2009 JULY 18, JEAN ELIZABETH CHAILLET 08:12 A.M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore (Month, Day, Year) | DECEMBER 14,1920 | MASSACHUSETTS 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 1 M 2 F Months 88 Yrs 031-10-5240 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1XYes 2 No PRINCE GEORGE'S MARYLAND BOWIE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16010 EXCALIBUR ROAD, #B203 20716 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc □Yes 2**X** No 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 K Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) UNITED STATES Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY GOVERNMENT** 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) GEORGE A. REXTROW FRANCES H. CROSSCUP 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1430 BLOCKTON COURT, CROFTON, MARYLAND 21114 LINDA CHAILLET/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20**0**9 JULY 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM CREMATION AND FUNERAL CARE, P.A., 814 BESTGATE ROAD, ANNAPOLIS, MARYLAND 21401 21. Signature of Funeral Service Lig Will Elover 7M00672 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🗌 Yes 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 □Yes 2 □No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 Linpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Physiclen: The **Physician** 

/Medical

**Examiner** 

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Physician/Medical

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Certification: To

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

item 27 is marked other than "natural", or items 23e or 28a-f shot other traumatic event, it a Middion Examinating the profiled at

n and Mental Hygiene.

Department of Health ar Important: If item 27 Is any Injury or other trau once.

**Physician** 

/Medical

Examiner

burial-transi and

signed by the attending physician be detached for use as the burial

certificate has been s rector, page 2 should

funeral director

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Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Hospital or Attending Pl 24 hours after death. Funeral Director; After the filled in by the e Funeral I completely To the F

State Registrar 31. Date filed (Month, Day, JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

24

	1 - State Registrar Amended#5	perFH FCHD KS	7/24/9	grtificate	of Death		Reg. No.	2000	250
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ner	4a. Facility Name (If not institution			4b. City, To	own, or Location of De			County of Dear	
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မှ	George Col	lentz			Sa	ndra Wes	t		
	19a. Informant's Name/Relationsh		I .	-	Street and Number or				_'
Ļ.	Sandra Coblenta				rrowsburg		· · · · · · · · · · · · · · · · · · ·		
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	4 Donation 5 □ Other (Sp		Brownsy		metery 7/2		1		e, Maryl
	21. Signature of Funeral Service I	Licensee			Address of Facility	Stauffe			
	1 ountreey	Stauffer			. Maple Av			C, FID 2	
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Timothy	Wa

nothy Warren	Clari	rke State of Maryland / Department of Health and Mental Hygie	ne
motily Trainen	1	1- For State Certificate of Death	Reg. No.
Physicia			te of Death 3. Time of Death onth Day Year 1315 hrs
ledical Exami	ner	1 MOTHY WARREN CIAINS	y 27, 2009 Year 1315 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cambridge Cambridge	Dorchester
		620 Diauley Avenue   Kilodor 2/Mrs   8	Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funeral		5. Social Security Number 6. Sex Min. Months Days Hours Min.	ug, 2,1989 Foreign Maryland
Director		811-83-33(c)	09,2,17011
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
		MD Dorchester Cambridge	1 Ves 2 No
Aaryland 28a-f show at at once.	Director	10e. Street and Number	10g. Citizen of What Country?
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she as Examiner must be notified at once	Dire	820 Bradley Avenue	USA
with ms 23.	la l	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Cuban Mexican Puerto Rical	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc.
death	Funeral	1 Never Married 2 Married 1 Yes 2 No	specify: Black
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hours 'natui		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4 or 5+)	
36 sin 72 than '	e e	Pallet Repairman  17. Father's Name (First Middle, Last)  18. Mother's Name (First Middle, Last)	V Food Processing
15-0036 filed within 72 Hygiene d other than 's, the Medical	Completed	17. Father's Name (First, Middle, Last)	
21215-0036 und be filed within 72 hou Mental Hygiene marked other than "nat	Be	TIMOTHY THOMPSON SIMON	Deute Number City or Town State Zip Code)
	2	19a. Informant's Name/Relationship (Type, Print)	
i, MD 2 and 2 shou ealth and N tent 27 is r traumatic		Simone Clarke 820 Bradley A Venus  20a. Method of Disposition  20b. Place of Disposition (Name of cemeylery, Da	
ore, es lar of He fite	Н	1 Burial 2 V Cremation 3 Removal from State crematory or other place)  4 Donation 5 Other Specify:  MID Shove Crematical 8/3	109 Cambridge, MD.
imC Pagement Trant:		4 Donation 5 Other Specify:   Mid Shove Cyemotics   Specify:   22 Name and Address of Facility	PA.
Baltimore, permit. Pages 1 a Department of Ho Important: If it injury or other t	1	21. Signature of Funeral Service Licensee	sti Cambridge, MD, 21613
Physiciar	-	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  23. Name and Address of Facility  23. Name and Address of Facility  23. Name and Address of Facility  23. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23. Name and Address of Facility  24. Name and Address of Facility  25. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and Address of Facility  29. Name and Address of Facility  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  26. Name and Address of Facility  27. Name and Address of Facility  28. Name and Address of Facility  29. Name and	piratory arrest, shock, or hea Approximate Interval Between Onset and
/Medica	d:	failure. List only one cause on each line. Immediate Cause (Final disease a. <b>Asphyxia</b>	Death
`xamine		or condition resulting in death)  Due to (or as a consequence of):	
	_	Sequentially list conditions, b.  b.  b.  b.  Due to (or as a consequence of):	
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Box 68760, e death certificate by the attending physical for use as the burner of the burner as the burner of the	sician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	Month Day Year
× 68	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
Bo e deat the at	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
that th	by P		1 Yes 2 No 3 Probably 4 Unknown
Aecords, P.O. Box 68760, The law requires that the death certificate be case has been signed by the attending physicical above the boundary of the control of the strength of the control of the second by the strength of the second by the strength of the second by the s	ed be	Propoxpnene and arconor asc	24a. Was an 24b. Were autopsy findings available prior to completion of cause of
ord aw rec			performed? death?
	Completed	26.Place of Death (Check onl	1 Tes 2 110 1 100 -
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic to the Funeral Director: After this certificate has been signed by the attending physics.	iffication: To Be Con		
of Viring Physical After this	2	1 Ves 2 No  28b. Time of Injury 28c. Injury at Work?  28 Aparent of Death 28 Aparent of Death 28 Aparent of Death	d. Describe how injury occurred subject placed plastic bag
on on on on the state of the st	ion:	1 Natural 5 Pending Fd 7/27/09 Fd 1:00 pm 1 Yes 2 X No C	over head
ivisior or Attend after death Director:	Fical	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28 X Suicide 6 Could not be	3f. Location (Street and Number or Rural Route Number, City or Town, State) 820 Bradley Ave
Divis Hospital or A 24 hours after	Certification:	4 Homicide determined (Specify) found at home	
D) To the Hospital Within 24 hours To the Funcral			ue to the cause(s) and manner as stated.  the time, date and place, and due to the cause(s)
To the within To the	completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, if my opinion, death essential and manner stated.  29c. License number	29d. Date signed (Month, Day, Year)
	Ž	29b. Signature and title of certifier.  O.C.M.E.	July 28, 2009
		D_r C_m	
		30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201
	Ctat	24 Pair filed (March Per York) 32 Penistrar's Signature	
	Stat	1111 9 1 2000 A	

Registrar DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 09 100 AM 2009 Walter Dotson, Jr Leon 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico poninsula Regional Medical Cente alisbur If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 1 X M 2 ☐ F Months Days 219-36-6672 68 07-28-1940 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Md. Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7043-2 Williamsburg Church Rd. 21643 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🗖 No 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Family Trucking Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Leon Dotson, Sr. Ada Lauvenia Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7043-2 Williamsburg Church Rd. Hurlock, Md. Christina Dotson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) John's Cemetery 107-25-09 Preston, Maryland 22. Name and Address of Facility Bennie Smith Funeral Home 1. Signature of Fundal Service Licensee 516 S.Main St., Hurlock, Maryland 21643 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Thummonia with Septic Shock Due to (or as a consequence of): Respisation and round feither Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Supro Son priouder tocky condia Due to (or as a consequence of): non & mold cell et of theling, metaltette 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Obstruction lung discore 1 Yes 2 No 3 Probably 4 Unknown Levere Our canopites 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 🗖 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

Be

**Funeral** 

Director

d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, It. M. dichl. Exa. and the profile of a standard or the

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev

Pages 1

Maryland 21215-0036

Baltimore,

Examine burial-tran Physician/Medical use

and Box 68760, the attending physician certificate be ō signed by the a Ö ģ Division of Vital Records, should I cate has t page 2 s within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page the Hospital or

Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No 2 Certification:

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide

29b. Signature and title of certifier

5 ☐ Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

00014314

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 7/15/09

TLS 3 State

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Medical

29a, Certifier

31. Date filed (Month, Day, Year) 17 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
12 Mp. + P. Klug. 100 E Cowoll Strut, Solis bury, Md. 2180/ pare

Registrar

			State of Maryland  1 - State of Maryland Registrar Ameno#23aPrt.1PerPhys.PCCr		artment of H rtificate of I		Mental Hy	giene Reg. No.	009	25032	
			Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death	
	iysici: Medic		John Davis, Jr.			Month July	9 2009 12:25a <sup>M</sup>				
7	camin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea	ath	4c. Co	ounty of Death		
*			Southern Maryland Hospital	of hirthday	Clinto	n If Under 24 Hi	rs. 8. Date of Bir		ince Ge	orge's	
	neral ector		5. Social Security Number 6. Sex 7. Age (In yrs. la 1 ★ 2 F 79	Yrs.	Months Days	Hours Mi		ay, Year)	Col	intry)	
			Usual Residence of Decedent				2/30/1	930	wası	ington, DC	
ırylan	Tal.	ŗ.	10a. State 10b. County 10c. City,	Town or Lo	cation					10d. Inside City Limits	
Ba-f	all I	ecto		ple H					4114	1 ☑ Yes 2 ☐ No	
with th	20	Dir	10e. Street and Number		10f. Zip Code				n of What Cou	untry?	
Jeath	THE STATE OF	Funeral Director	4107 Leisure Drive  11. Marital Status  12. Was Decedent Ever in U.S	. 13. V	20748 Was Decedent of H	ispanic Origin?	(Specify Yes or No	USA - 14	. Race - Amer	rican Indian,	
after o	alther	Fur	1 ☐ Never Married 2 🛣 Married 1 ☐ Yes 2 🛣 No	'	f Yes, specify Cuba	in, Mexican, Pue	erto Rican, etc.)		Black, White		
ວ-ບບວດ 72 hours aft natural".or	Exa	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		I⊡Yes 2. Mo	Specify:				Slack	
72 h "natu	Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Its Model Extended to use to in tillied at once.	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of w	orking	16b, Kind	of Business/I	ndustry	
ZIA J withir giene.		dwa	Elementary/Secondary (0-12) College (1-4or 5+)		ervisor	"		Fode	ral Co	vernment	
filed Il Hyg		Be C	17. Father's Name (First, Middle, Last)	bupe	IVISOL	18. Mother's N	ame (First, Middle			Veriment	
VIANO VIII DE FIIE Mental H Prived Offi		To E	John Davis, Sr.		j	Evo	ola Wesl	.ey			
2 sho			19a. Informant's Name/Relationship (Type. Print)		g Address (Street						
t and lealth	ther to		Elaine White Davis		Leisure		Temple H:		MD 20 ation - City or 1	1748	
ages intoff	nt of h		1 M Burrai 2 Cremation 3 Hemoval from State	-	sition (Name of natory or other plac		7/2009				
Dallinor  Dermit. Pages Department of	injury		4 Donation 5 Other (Specify)	/7	n Cemete . Name and Addres		.		wood,		
Dep Dep	any ir		Ille Mill		401 Blade					20722	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory, arrest, shock, or heart failure. List only one cause on each line. Massive Myocardial Infarction  Approximate Interval Between Onset and Death								
Physic	cian		Immediate Cause (Final disease or condition	. t	Myocar	uiai i	ITALCUL	-		Onset and Death	
/Med			resulting in death) a. Due to (or as a conseque	ence of):		1)51					
Exam	iner	L.	Sequentially list conditions, b.	10-116							
ted	nsit	nine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	stice of j.							
exect n and	al-tra	Examiner	that initiated events c c Due to (or as a consequence consequence)	ence of):							
icate be executed physician and	the burial-transit	edical	d		<u>.</u>						
rtificating phy	as th	Medi	IF FEMALE:								
ath cel	for use as 1	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnan	death 3	Ectopic pregnanc	y		23	d. Date of deli Month	very Day Year	
the de	thed fo	ysici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of de 9 ☐ Unknown	ath 5	Other (specify) _				Monar	Day , oa.	
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v requires to been sign.	n signed by the a ild be detached f	d by					1 🗆	Yes 2□	No 3□ Pr	obably 4 Unknown	
aw rec	le 2 should l	Completed					24a. Was		24b. Were au	topsy findings available	
The la	n. After this certificate ha funeral director, page 2	mo					- auto perfo 1 □Yes	psy ormed? 2 X No	death?	completion of cause of	
arifica is		BeC	25. Was case referred to medical examiner?			26. Place of D	eath (Check only		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
Physic this on	al dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 🔀 E			4 LI Nursing	Home 5 ☐ Res	idence 6 [	Other (Spec	cify)	
	funera	io ::	1 Natural 5 □ Pending (Month, Day, Year)	28b. Time of Injury	Work		28d. Describe	how injury o	occurred		
Attending at death.	otor: y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At hon	ne, farm, stre		Yes 2□No	28f. Location	Street and i	Number or Ru	ral Route Number,	
after Dire	d in b	Certification:	4 Homicide determined building, etc. (Specify)	)	, , , , , , , , , , , , , , , , , , , ,			wn, State)		,	
fospita t hours unera	within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	edical C	29a. Certiffier (Check only Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.    Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
the P		Medi	one) and manner stated.  29b. Signature and title of certifier		29c. License				signed (Monti		
<b>₽</b> § ₽	8	-	and and or definite		200. LIGHTS	100	_		1)6/60		
,			30. Name and address of person who completed cause of death (Item	23a) (Tvne	Print)	405	)			-	
25			Eric Medonald 7503 Sx	UM.	HSRd	. Clir	iton (	nd	2073	5_	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signat.  JUL 2 3 2009	ire.							
Re	egistra	ar	JUL 2 3 2009 Benera D. Ja	ver							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUI CIHHHBU MD 22

Year)

**Physician** /Medical

Examiner

**Funeral** 

Director

28a-f show

**Funeral Director** 

Be Completed by

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Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expressions result be the filled at

death with the Maryland

For State Registrar		I / Department of Health and Men Certificate of Death				Reg. No. 2009 25033						
Decedent's Name (First, Middle, Last)					2	Date of Death     Month     Day     Year     3. Time of Death     Year						
Don Francis Dunl	ар,					July	28	2009	1421 P M			
. Facility Name (If not institution, give street and number)		4b. City,	Death	4c. County of Death								
1153 Singerly Road Social Security Number 6. Sex 7. Age (In yrs.	last hirth	E1kton ast birthday) If Under 1 Year   If Under 24 Hrs.					8. Date of Birth 9. Birthplace (					
212-30-1633	Yr.	Months			Min.	(Month, Day, SEPT 17.	Year) 1937	Co	ountry) rvland			
sual Residence of Decedent						,,,,						
a. State 10b. County 10c. Ci	ity, Town c	or Location							10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	E1kto						077	of What Co				
e. Street and Number			p Code			10	•					
1153 Singerly Road  Marital Status 12, Was Decedent Ever in U	16	21921 S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-							States			
. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married	,.0.	Mas Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)						14. Race - American Indian, Black, White, etc.				
Widowed 4 □ Divorced   If Yes, Give Year or Dates:		1 □Yes 2 🎇 No Specify:						Specify: White				
15. Decedent's Education		ecedent's Usu			of working		6b. Kind	of Business				
(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	(Give kind of work done during most of working life. DO NOT use retired)										
12	Se1	Self-employed Truck Driver						Trucking  Middle, Maiden Surname)				
7. Father's Name (First, Middle, Last)							aruen SU	nanie)				
John Dunlap	105 1	Anilina Addr	n /Ctrant =	Ada		S Route Number,	City or T	own State	Zin Code)			
Pa. Informant's Name/Relationship (Type. Print)		•	•			kton, M		921	2/p 00de)			
Don F. Dunlap, Jr./Son  a. Method of Disposition 20b.		Disposition (Na crematory or			Da				Town, State			
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery,	crematory or	other place									
4 Desertion 5 Dother (Consist)	F112+0			1 44	ugus	t 1,	T 11	,ton	MD			
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4 ☐ Donation 5 ☐ Other (Specify)	Elkto	on Ceme	etery nd Address Home	2 s of Facility for F	009 'uner	als, P.	Α.		MD 21921			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State

Registrar

DHMH 17 Rev 1/2001

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32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

09-05608 Jordan Farrell

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 17, 2009 1814 hrs Medical Examine 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** 5 Director 0-23-03 7-37-4874 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10b. County 1 Yes 2 No 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Headin and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10e. Street and Number U.S.A 7 0011 08 house 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Sever Married 2 BlACK 2 2 Yes 1 Yes 2 i No specify: If Yes, Give Yaar Divorced Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Student Com 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CAmphell ERILA Be Kohere FARnel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship Trenhouse ST. New wood DCZ6011 phell-Mothe ERICA 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State Surtland 2 Cremation Burial 67-25-69 LINCOLN Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 814 Upsha ST Niw The House & Williams MO1182 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death Medical a. Smoke Inhalation Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED #7perFH7/22/09.BMW.McCo UNPENDED 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Month Day Year 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 ✓ No 3 Probably 4 Unknown <u>\$</u> Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed' death? Yes Yes 2 No 26.Place of Death (Check only one) 25 Was case referred to medical æ Other 4 examiner? Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 မ 1 V Yes 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject in house fire Certification: Jul (Month Day) 1710 hrs Yes 2 V No Natural Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 5417 56th Place #101, Riverdale, MD 3 Could not be Suicide (Specify) Multi-Family Apt. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 19, 2009 O.C.M.E. grassi G 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 OCME Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month) Pay, Year) egistrar's Signatu State 2009 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

Physicia		1. Decedent's Name (First, Middle, Last)				Tental Hyg  Re  2. Date of Deat		3. Time of Death				
/Medic		JAMES BOYD FOSTER, JR.			JULY	17, 2009	<b>0650</b> <sup>M</sup>					
Examin		4a. Facility Name (If not institution, give street and number)  223 MORRIS STREET		4b. City, Town, or Location of Death  OXFORD			4c. County of Death <b>TALBOT</b>					
Funeral Director	or	219-01-6354 X 2 F 9	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN. 22,	Year) 9. Birt Co 1919 MAR	hplace (State or Foreign untry) YLAND				
72 hours after death with the Maryland "natural", or items 23a or 28a-f show digal Examine must be notified at		Usual Residence of Decedent  10a. State 10b. County 1		10d. Inside City Limits 1 ☐ Yes 2 ☐ No								
28a-f	Director	MD. TALBOT OXFORD  10e. Street and Number 10f. Zip Code					Og. Citizen of What Co					
3a or	E Di	223 MORRIS STREET		21654			U.S.A.	,				
f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exerciter must be notified at	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ XMarried  1 ☐ Yes, Give	ARMY	Was Decedent of Hi If Yes, specify Cuba I □ Yes 2▼ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.					
ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		dent's Usual Occupa			W	HITE				
e. an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)   College (1-4or 5+)	ing	16b. Kind of Business/Industry  U.S. ARMY								
nt, the		12 4	12 4 OFFICER									
ic ever	To Be	17. Father's Name (First, Middle, Last)  JAMES B. FOSTER				Name (First, Middle, Maiden Surname)  E. CHINNOCK						
is mar		19a. Informant's Name/Relationship (Type. Print)	1				, City or Town, State,	Zip Code)				
em 27 ther tr		JEANNE K. FOSTER/ WIFE  20a. Method of Disposition	P. O.  20b. Place of Dispos	BOX 354			20c. Location - City or	Town, State				
ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CHESAPEAK	natory or other place E CREM. C	TR. 7-19	-09 S	YEVENSVILL					
Important: If Item 2 any Injury or other once.	8 80	21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A.  200 S. HARRISON STREET, EASTON, MD. 21691										
		23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.	ie death. Do not enti	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death				
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onld be	ed by	Ostecarturitis	1,240	1 res 2 No 3 Probably 4 Unknown								
,	Completed		perfori	Was an autopsy available prior to completion of cause of death?  1 □ Yes 2 □ No								
completely filled in by the funeral director, page 2 should be detached for use a	Be (	25. Was case referred to medical examiner?		l out	26. Place of Dea							
rai dire	ျ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient  27. Manner of Death 28a. Date of Injury	2 ER/Outpatien		4 LI Nursing H		ence 6 Other (Spe	ecify)				
5	ation	1 Natural 5 Pending (Month, Day, 1 2 Accident investigation		Work	? Yes 2 □ No		,,					
	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury building, etc.	/ - At home, farm, str (Specify)	reet, factory, office		28f. Location (S City or To w	treet and Number or R n, State)	Rural Route Number,				
libicit iiii	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of and manner state	xamination and/or in									
сошр	Me	29b. Signature and title of certifier	2	29d. Date signed (Month, Day, Year)								
		CARS 6 5		DY	-7492		July 1	7, 2009				
		30. Name and address of person who completed cause of dea	th (Item 23a) (Type,		Jettre	y T.J	Dentor	1,110				
P		555 Cynwood Dr.	CESTON.	VVI '	21100	( )		,				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 18, 2009 July 6:45P M **Physician** Farrell Norman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles 504 St. Mary's Ave. La Plata | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 17,1940 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ₹ M 2 □ F 68 215-36-4616 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examener must be notified at 1 ☐Yes 2 ☐ No Director MD La Plata Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 504 St. Mary's Ave. 20646 USA Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "na any Injury or other traumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Public Facilities 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be John Brent Bradburn Elanore Josephine Cooksey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 294, Bel Alton, MD Agnes Hindle/Cousin 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Crem. 7/23/09 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee <sup>22</sup>AREHARI ECHULS FUNERAL HOME, P.A. M00945 C. Que 211 St. Mary's Ave. La Plata, MD 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Jubete nelliter Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year In the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ E No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier edical completely (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Leatherwood, M.D. 12070 Old Line Ctr. Waldorf, MD 20601 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 2 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician**  $A^{\mathsf{M}}$ Ruth Ficken Gustad 07 2009 16 4:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bay Ridge Nursing & Rehabilitation Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🕅 F 86 Months Days Hours Min 535 26 9750 Indiana 06/15/1923 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, If "Medical Examinar must be notified at Director tyv Yes 2 ☐ No MD Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 900 Van Buren Street 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White 2 3 ☐ Widowed 4 ₺ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elma Louise Michel Clarence Elwood Ficken 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2305 Ida Lane/Hays KS 67601 Ann Gustad Leiker (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 7/20/2009 Alexandria VA 22. Name and Address of Facility 21. Signature of Funeral Service Licef Advent Funeral & Cremation Services Falls Church VA and Annapolis MD Melanies 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Por in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Ď The law requires that signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ be 4 nknown 1 Yes 2 🗌 No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.

Funeral Director: After thi letely filled in by the funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the I within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DAVE

Year)

31. Date filed (Month, Day,

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32. Pegistrar's Signati

ANNAPELIS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For AMEND#10e+19operFH,7/28/09,BW,Moon Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** <u>12:</u>30 Рм 2009 Nelson B Gilbert July 16. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 81 578-42-6814 June 11, 1928 Michigan Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at MD Montgomery 1 ☑ Yes 2 ☐ No Chevy Chase Funeral Director 10g. Citizen of What Country? 10e Street and Number 5075 10f. Zip Code Bradley Blvd #2 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 SYes 2 No If Yes, Give Year or Dates: 1952–61 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ş 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d other than "natu event, the Medical ... withir. ... wental Hygiene. ... 27 Is marked other than "? r traumatic ever\* Elementary/Secondary (0-12) College (1-4or 5+) Pentagon <u>Photo journalist</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nelson T Gilbert Wildah Cummings ဥ 507 dailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Mary Gilbert, Spouse <del>5705</del> Bradley Blvd #2, Chevy Chase, MD 20815 Department of Health Important: If Item 27 any Injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cheltenham Cemetery 7/23/09 Cheltenham, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. immediate une (Final disease or condition resulting in death) Hypoxic respiratory failure **Physician** /Medical Due to (or as a consequence of): Examiner Aspiration pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Abdominal disorder Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical Cardiomyopathy IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown End stage renal disease on hemodialysis certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Malnutrition autopsy performed' 2 🗆 No 1 ☐ Yes 2√ No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Phospital or Attending P 24 hours after death. Funeral Director: After the telety filled in by the funeral 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 16/09 S'HDARSHAN SWAMD 065312 +1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

1230

DHMH 17 Rev 1/2001

Sudarshan Siva

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2009

31. Date filed (Month, Day, Year)-

8600 Old Georgetown Rd, Bethesda, MD 20851

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year Leado Guy Grear 19 2009 12:43 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death George's 2234 Alice Avenue Oxon Hill Prince 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 € M 2 □ F Months Days Hours Min. 50 -11-1959 Wash. 579 84 1327 Usual Residence of Decedent D.C 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Oxon Hill MD 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2234 Alice Avenue #304 20745 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐Yes 2X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Produce Clerk Giant Food 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leado Grear, Sr. Carolyn Randolph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2074519a. Informant's Name/Relationship (Type. Print) 2234 Alice Avenue #304 Oxon Hill, MD Wife Patricia Grear 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln Cemetery 7/23/09 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf Md, 20601 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. proximate terval Between set appl Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an 1 ☐ Yes 2 HNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

The law requires that the death certificate be executed sician and burial-trans P.O. Box 68760, attending physician for use as the burial signed by the a Division of Vital Records, icate has been si , page 2 should b certificate I or Attending Physician: after death. Director: After this certifica director, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

death \

Director

Funeral

Completed by

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiliar roust to realined at

permit. Pages 1 and 2 should be filed within 72 hours after c De artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Example.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

Fequentiary flet constructs, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant ģ Completed 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 ☑ No Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 1 Matural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of cer

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hua Suite 101 Clinton mol 20735 axmi 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:40 P M John S. Groat 15 2009 July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Year)
Dec. 07,1932 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 76 Yrs. Social Security Number **Funeral** 1**∑**M 2□ F Months Days Hours New York 121-24-2579 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be redified at Anne Arundel Annapolis MD 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number within 72 hours after death with 21409 USA 1647 Homewood Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 □ No 1952
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify. Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal 12 should be filed within the and Mental Hygiene.
7 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) National Security Agency Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Abigail McGill John S. Groat 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is 1 1647 Homewood Road Annapolis, MD 21409 Joan Anne Groat / Wife July 16,200 Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, INC. 4 Donation 5 Dother (Specify) gnatury of Funeral Sevice Lions Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 3a. Part Enter the disease, of shock or heart failure. Lis Immediate Lause (Final **Physician** Myolardia resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Artery quentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. ☐Yes 2 ☐No the detached 9 Unknown 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 2 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/0 No has 2 □No certificate 1 ☐ Yes 1 ☐ Yes director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier STOCKBELL, MO 7/16/09 D46052

() State
Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

denur A. park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Bell, Mb 2001 Wedical Panhway amaprlis, Mb

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🦳 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month 7 CO Physician ordon 20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 **⊠** M 2 □ F Hours Yrs 001-16-2693 Director October 27, 1922 New Hampshire 86 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiliar meation of the 1 ☐ Yes 2 🛣 No Director Maryland Howard Savage 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8334 Woodward Street 20763 U.S.A Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or itel 1 ▼Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. 2 Specify: WJTT 3 X Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Howard County Elementary/Secondary (0-12) College (1-4or 5+) Secondary English Supervisor Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Ethel Kidder Seward Hayward 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; If Item 27 is any injury or other trau Sarah H. Ortega - Daughter 9656 Golden Rod Path, Columbia, Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park 07/25/2009 Rockville, Maryland 21. Signature of Funeral Se 103 22. Name and Address of Facility Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme lia e Cause (Final disease or condition resulting in death) Physician 515 /Medical Due to (or as a consequence of): difficle colitis Examiner lostridium Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown certificate has been s irector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Dursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 20 2009 DOGS3337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dovothy Secur, nd 25 Main Street Suite 200 Reisterstown, Md 21136 Dorothy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 22 JUL

Registrar DHMH 17 Rev 1/2001 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:10AM 19 2009 Robert Gorman Harrington July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester Berlin Nursing Home Berlin 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
May 4, 1924 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 X M 2 □ F 85 V٨ 579-18-9075 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. M. Alcal E. vi., i.e., outh be notified. 1 ☐ Yes 2X ☐ No Director Wicomico Willards MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21874 USA 36615 Purnell Crossing Rd. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. XYes 2 □ No 1 Never Married 2 Married 1 ∐Yes 2 🛛 No If Yes, Give Year or Dates: Specify: white ģ Baltimore, Maryland 21215-003 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HVAC HVAC Tech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Schreiner Dr. John S. Harrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 36615 Purnell Crossing Rd., Willards, MD 21874 Margaret Ann Harrington / wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern Shore Vet. Cem 7/27/2009 Hurlock, MD 4 □ Donation 5 □ Other (Specify) 21. Signa of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Parn. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCWO Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as for use yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) I□Yes 2□No signed by the a d be detached for P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ✓ ✓ No 24a. Was an autopsy performed? Yes No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes VINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day, Year) 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BA5+1

Harrington,

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and aldress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SHORE

29c. License number

29d. Date signed (Month, Day, Year)

SAUSBURY MD.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21 Day **Physician** 2009 Charles Curtis Hitch 8:30 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lakeside Assisted Living Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 6/17/1930 213-24-4413 1 X M 2 □ F 79 MD Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination to rotting at 1 ☐ Yes 2 XNo Director MD Worcester Snow Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 208 Coulbourne Lane 21863 USA Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: Specify: \$ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Accounting permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Curtis T. Hitch Virginia Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Lou Hitch - wife 208 Coulbourne Lane, Snow Hill, MD 21863 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 23, 09 Snow Hill, MD 4 Donation 5 Dother (Specify) Spence Church Cem. 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Melgnons /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen a 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has autopsy performed 1 ☐ Yes 2 🗷 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1∐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within ? 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7/21/09 1470 94 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5745304 MD 21804 NATERN BA 5+1 1415 5-DIV Shew vel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 22 2009 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 1532 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4b. City, **Examiner** 5. Social Security Number W Birthplace (State or Foreign Country) last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1 **№**M 2 🗆 F 213-42-0387 5/31/1942 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I's Modical Examinat notet by notified at 1 ☐ Yes 2√∑ No Director MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7449 Shortall St. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ Specify Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil Laborer Getty Oil 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Henry Harris Sr. Isabella Beatrice Warren ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Helen Christine Harris/wife 7449 Shortall St. Chestertown, MD 21620 item 27 other t 20b. Place of Disposition (Name of Emilianue I UM Church 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or or once. **X**☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/25/2009 Pamona, MD 4 Denation 5 ☐ Other (Specify) cemetery Signature of Funeral S and Elicensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 E. Dover St. Easton, MD 21601 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** poteusion disease or condition resulting in death) /Medical Due t ( r as a consequence of): Examiner Prepable Po Lumary Embolus VS Agreeded Typeretien Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine spital or Attending Physician: The law requires that the death certificate be executed tours after death. In the control of t GASTROINTESTINAL BLOOD Repable resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ■ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗹 Yes 2 🗆 No ¹□Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗑 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 P Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Hospital 29a. Certifier 1 🛃 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal

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State Registrar

(Check only one)

TOHN C

29b. Signature and title of certifier

JUL

and manner stated

TX

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IZABAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 23889

7/16/09

223 High Street, CHEStertown, Jud 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** William Thomas Hughes 9:20 2009 July /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Lakeside Assisted Living Salisbury 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 82 Director 08/30/1926 Pennsylvania 165-20-4009 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "hedical Eventine must be notified at 1 X Yes 2 □ No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Lakeside Assisted Living 105 21804 USA Schumaker Dr., Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: navy 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 2 white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) railroad general foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenny Hall Richard Hughes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau once. Rita Stevens/daughter 1010 Meadow Crest Dr., Kimberton, PA 19442 20b. Place of Disposition (Name of cemetery, crematory or other place)

St.John the Baptist 7/24/09 Allentown, PA

Slovak Catholic Church Cemetery

22. Name and Address of Facility
HOITOway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee aire H 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ASCVI disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the a P.O. 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) A 35: 37 8 4 examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVILO 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatl Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 147094 121/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATES 9 N 1415 sherr 5. NIV

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 22

32 Registrar's Signature

			State of Maryland / Department of 1 - State Registrar Certificate of			iene <sub>eg. No.</sub> つ 〇	10 250'6
	Physicia		Decedent's Name (First, Middle, Last)  Thelma L. Hammond		2. Date of Death Month July		3. Time of Death 09 1855 P <sup>M</sup>
1	/Medic Examin	er		or Location of Death		4c. County of Ceci.	1
	Funeral Director		5. Social Security Number 212-76-1580 6. Sex 7. Age (In yrs. last birthday) 1 If Under 1 Yea Months Day		8. Date of Birth (Month, Day, April 15	, 1925	Birthplace (State or Foreign Country) Delaware
Maryland 21215-0036	nd 2 should be aith and Mental 27 Is marked c	To Be Completed by Funeral Director	11. Marital Status  1	21921 Decedent of Hispanic Origin? (Specify Yes or es, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 No Specify: It's Usual Occupation of of work done during most of working NOT use retired)		14. Race-Black, Specify: 16b. Kind of Busin In Her Maiden Surname)	ed States American Indian, White, etc.  White ness/Industry  C Own Home
	Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition  1	July 2009	erals. P	19311 20c. Location - Ci E1kton A. kton. MD	n, MD
	hysician and hysician and the private transit the private transit the private transit the private transit the private transit the private transit tran	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Chassic KIDNE y  Due to (or as a consequence of):  b. HYFET F->SIVIZ  Due to (or as a consequence or):  Chassic KIDNE y  Due to (or as a consequence of):  ANEMIA  Due to (or as a consequence of):  ATRIAL FIBLUAT	DISEAS	E		Interval Between Onset and Death
O. Box 68	the attending phoche for use as the	Physician/Medi	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)			23d. Date Mont	·
rds, P.	an signed by the aud be detached in	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause ThAoMAo たりらしら	given in Part I.	23e. Did to		oute to the cause of death?  B Probably 4 Unknown
of Vital Records,	certificate has been s ector, page 2 should	Completed	25. Was case referred to medical	26 Piace of Dea	24a. Was a autops perfor 1 □ Yes	med? de 2 XNo 1 E	ere autopsy findings available ior to completion of cause of eath? Yes 2 Ko
Division of Vir	death. :tor: Affer this certific / the funeral director,	Certification: To Be	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  27. Manner of Death 1 Valural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury At home farm street factory office.	ome 5 Resid	dence 6 □Other		
						n, State)  cause(s) and man	nner as stated.
P ST	within 24 To the Fu	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. Lic	ense number ) 00 6 5 7 3 3	<b>S</b>	29d. Date signed	(Month, Day, Year)
				16H sm	et, 121	CK704, h	ND 21921
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 05 2009				

DHMH 17 Rev 1/2001

DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year 9:35PM 2009 701 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1801 E. Jefferson St., #212 Rockville Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours 1 □ M 2 🖾 F 102 Yrs. Aug. 6. 1906 070-24-5881 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Montgomery Rockville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #212 20852 United States 1801 E. Jefferson St., 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ▼ No Specify: white 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Children's Clothing Retailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Schrek Samuel Blau 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9013 Willow Valley Way, Potomac, MD Michael Kramer, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/22/09 Judean Memorial Gardens Olney, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part . Ent. Ve disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Fine) 20012 Approximate Interval Between Onset and Death COLON Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 3 🔲 Ectopic pregnancy Live birth 2 Fetal death
Pregnant at time of death Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown POTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 5 Pending 1 □Yes 2 □No investigation

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

Director

28a-f show

Director

2

Completed

27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be required at

filed withir Hygiene.

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1 and 2 s' if Health a

permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other

Baltimore, Maryland 21215-0036

Box 68760. certificate be

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Records,

Division of Vital

and physician a s the burialthe SS attending for use as nse page or Attending Physician: The

dical After To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

fication: To Be Completed by Physician/M	<i>*</i>
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Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ROCKVILLE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNA KORZAN 1801 EAST DEFFERSON ST

State Registrar

Medical

31. Date filed (Month, Day, Year) 22 JUL

09-05616 Amar Kamble Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ar Kamble	1.	State of Maryland / Department of For State Certificate or		Reg. No	2019 250
Physicia	R	egistrar  Decedent's Name (First, Middle,Last)	Dodin	2. Date of Death	3. Time of Death
Physicia edical Examir		Amar Scott Kamble		Month Day July 17, 2009	2201 hrs
	4	ta. Facility Name (ii not institution, give ou oot and visite or	4b. City, Town, or Location of Death	· 1	4c. County of Death  Montgomery
		7825 Briardale Terrace	Derwood  If Under 1 Year   If Under 24Hrs	1	M/DD/YYYY) 9. Birthplace (State or
Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min		Foreign
Director			s	Bec. 31,	1307
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca	tion		10d. Inside City Limits
<b>1</b>	: اچ	Maryland Montgomery Derwoo	d		1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10g. C	Sitizen of What Country?
eath with the Maryland items 23a or 28a-f shov ust be notified at once.	- 1	7825 Briardale Terrace	20855	De seife Ven er No	14. Race - American Indian, Black,
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. If	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	White, etc.
or deat	됩	1 Yes 24 No	Yes 2 No specify:		Specify: Biracial
hours after 'natural", Examiner	홠	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's Usual Occupation (Give kind of	work done 16t	o. Kind of Business/Industry
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5-0036 iled within 72 Hygiene. d other than '	Completed			ne (First, Middle, Maid	
Filed v Hygi d othi		17. Father's Name (First, Middle, Last) Ambaji Narayan Kamble		ow Bridgha	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygieneith and "matural", or items 23a or 28a-f she art is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	To Be		ng Address (Street and Number or	r Rural Route Number	, City or Town, State, Zip Code)
and 2 shoulesth and N tem 27 is n traumatic		Amy Low Kamble/Mother 7			erwood, MD 20855
두 명분 모종	1	20a. McCried of Bioposition	osition (Name of cemetery, other place)	July 25	
MOF Pages nent of ant: If	- 1	4 Donation 5 Other Specify:	Memorial Park	2009 I	Rockville, Maryland
Baltimore, permit. Pages I at Department of Hee Important: If ite injury or other tr		21. Si , ature of Funetal Service Licensee	Name and Address of Facility Francis J. Colli	ns Funeral	l Home Inc Silver Spring,MD 209
	_	23a. Part I. Enter the disease, or complications that caused the death. Do not ente	r the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart Approximate Intervention
Physician /Medical		failure. List only one cause on each line.			Death
:aminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			
		Sequentially list conditions, if any leading to immediate b.  Due to (or as a consequence of):			
	ine	cause. Enter Underlying Cause			
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Vit; hysici this o	۱ ٥	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati		rsing Home 5 Re	esidence 6 Other: Scene
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/isior r Attenc ter death irector: n by the	l ă	2 Accident Investigation Jul 17, 2009 2156 hrs 28e. Place of Injury - At home, farm, s		28f. Location (Str	reet and Number or Rural Route Number, C
Division of Vital Records, tal or Attending Physician: The law requirers after death.  Director: After this certificate has been selled in by the funeral director, page 2 should it.	Certification	3 ✓ Suicide 6 Could not be determined (Specify) Residence		or Town, Sta 7825 Briardale	rte) Terrace, Derwood, MD
pspi hou unea			ccurred at the time, date and place,	and due to the cause	(s) and manner as stated.
To the Ho within 24 To the Fi	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or inves and manner stated.			29d. Date signed (Month, Day, Year)
CHESTER NO.	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		July 18, 2009
<b>3</b>		(Mel C	U.C.IVI.E.		
	1	30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Pen	nn Street, Baltimore, MD 21	201	
		And Projection & Signature			
Regi	State	JUL 22 2009 June 1. 19	enter		

		Plea	ase Type or F							ble.		
		ForState	State of	Maryland		rtment of H <i>tificate of L</i>		Mental Hygi	65		1 0	
Physicia	n	Registrar  1 Decedent's Name (First, Midd	fle, Last)	ana		incate or t	Jealli	2. Date of Death	g. No.	Year 3. Time of Dea 4'. 20.		
/Medic		4a. Facility Name (If not institution	on, give street and num			4b. City, Town, or	Location of Dea	th	4c. County		,,,,,	
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Funeral Director		5. Social Security Number 098–14–4682	6. Sex 1 □ M 2 <b>XX</b>	7. Age ( <i>In yrs. I.</i>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 1922	9. Birthplace (State or Fo Country) NEW YORK	reign	
and w	-	Usual Residence of Decedent  10a. State 10b. County	v	10c. City	, Town or Loc	cation				10d. Inside City Li	imits	
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h the	Director	10e. Street and Number		LEAD	LON	10f. Zip Code		10	g. Citizen of What Country?			
th wit		28889 JASPER 1	LANE			21601		1	USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be netfled at once.	y Funeral	11. Marital Status 1 □ Never Married <b>XX</b> Mar	rried Armed For 1 ☐ Yes If Yes, Giv	2 X No	1	Vas Decedent of H fYes, specify Cuba I□Yes 2 <b>XX</b> No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Bla	ce - American Indian, ck, White, etc. y: <b>WHITE</b>		
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To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live b	come of pregna pirth 2  Feta nant at time of d own	l death 3	Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i>	у		1	ate of delivery onth Day Yea	r	
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nding Phath. r: After the funeral	ation:	27. Manner of Death 1 Matural 5 Pendi 2 Accident invest	ing (Mont tigation	of Injury h, Day, Year)	28b. Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe ho	w injury occu	rred		
The performed of the pe									ber or Rural Route Number	i		
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State Registrar LN, EASTON, MD 21601

DR. WILLIAM H. WOOD, MD, 501 DUTCHMANS

31. Date filed (Month, Day, Year)

JUL 2 1 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 3:15 PM M. Janett Kirk 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner hake the alisb Viconico Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🛛 F Months Days Hours . Director 12-2-1912 South Dakota 468-01-2958 96 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, its firstical E.a., it we must be notified at 1 ☐ Yes 2 X No Director MD Wicomcio Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 300 Lemmon Hill Lane 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2∭X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: White Specify: 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, its Maonce. Elementary/Secondary (0-12) College (1-4or 5+) Secretary <u>Department of Agriculture</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Frank Naeve Nellie Bergstresser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pers. Charles R. Dashiell, Jr.-Rep 126 E. Main Street, Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-22-2009 | Delmar, Delaware Crematory of Delmarva 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): **Examiner** THRIVE AILURR Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes No
9 Unknown 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. X-M 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes □No 24a. Was an autopsy perform this certificate 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 1€ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Sther (Specify) 405 PICE Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

and manner stated.

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0058410

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nereido 11:37 PM 18 300 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h. City Town, or Location of Death Examiner Johns Hostins Baysew Medical Center Baltinore Rolling If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F 583-38-5080 85 Puerto Rico Director January 30, 1924 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Wedical Examiner must be mailfied at Director 1 ☐ Yes 2 🗷 No Florida Orange Orlando 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10913 Buckwater Court 32817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1⊠Yes 2□No Specify: Completed by Specify. 3 X Widowed 4 ☐ Divorced Puerto Rican White 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Commonwealth of Puerto College (1-4or 5+) 5+ **Educator** Rico School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerardo Lopez de Victoria Francisca Bouillercee ၉ or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haydee Cristina Oliveras - Daughter 448 Winter Walk Drive, Gaithersburg, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chapel Hill Cemetery 07/24/2009 Orlando, Florida 21. Signature of Funeral Service Line 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 29a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) **Physician** Arrhull /Medical Due to (or as a consequence ) f): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed sician and burial-trans Due to (or as a con equence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Yea Day 5 ☐ Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 2X ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident To the Hospita ... within 24 hours after death.

To the Funeral Director: Aft 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 04383

State Registrar

DHMH 17 Rev 1/2001

5. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Greenough

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear Month **Physician** Milbourne LeCompte 2009 :25 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ako 5 0 b Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral 1X** M 2 □ F Months Days Hours 217-30-9866 74 05/28/1935 **Director** Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Tyes 2 No Director Wicomico Maryland Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 320 Gunbys Mill Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after In the recession of the 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ white 3 Widowed 4 Divorced Guard Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) health care nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lacy Milbourne LeCompte Mary A. Twilley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Sandra H. LeCompte/spouse 320 Gunbys Mill Dr., Salisbury, MD 21804 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition P 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Injury or 7/22/09 Salisbury, MD Salisbury Crematory 4 Donation 5 Dother (Specify) Signature of Funeral Service Licenses P. Name and Address of Facility Holloway Funeral Home Professional Association Jarre 34 501 Snow Hill Rd., Salisbury, MD 21804 Compron CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final DISIZASIZ Physician ALZHB/MR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be execute attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 2 5 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) HOS PICAL 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No Accident investigation after death Director: 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral

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State Registrar

Medical

29a, Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bux

Registrar's Sign

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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1)005 8410

29d. Date signed (Month, Day, Year)

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. OFOE 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 7 Year **Physician** 12:13 AM 2009 METCALF 17 MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL MEDICAL CENTER Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Aug. 15, 1914 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2/CKF 94 Massachusetts **Director** 214-52-8787 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Medical Exp. of the mast be notified at 1 ☐ Yes XXNo Directo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 536 Corbin Parkway 21401 Funeral death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐Yes XX No altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 💢 🗸 🗸 Specify. Specify: White ð ¾X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental I Pages 1 and 2 should be Joseph Makuch traumatic Bridget (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an important: if item 27 is any injury or other trau Preston Metcalf, Jr./son 536 Corbin Parkway Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \_5 ☐ Other (Specify) Neterans Cemetery 7/21/2009 Crownsville, Maryland 21. Signatur of Fineral en ce Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 JUM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UPPER GASTROINTESTINAL HEMORRHAGE. **Physician** HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine iptial or Attending Physician: The law requires that the death certificate be executed ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

within 24 hours a

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completely filled To the Hospital

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of D66753

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timothy M. Casstack Medical Perkway, Annapolis 2001 31. Date filed (Month, Day,

State Registrar

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Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registral Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 11:23 a<sup>™</sup> 2009 July 20, KENNETH WAYNE MILLER. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Worcester Pocomoke City 3233 Sheephouse Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea 9/14/1957 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **№** M 2 F Months Days Yrs. Missouri 51 498-62-1165 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Pocomoke City Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21851 USA 3233 Sheephouse Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ŽVes 2 □ No If Yes, Give Year or Dates: Navy 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Senior Systems Analyst 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Evelyn Elaine Groshans Kenneth Wayne Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3233 Sheephouse Rd., Pocomoke City, MD 21851 Karen Anderson Miller (wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 7/25/2009 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Holloway Turieral Home, Professional Association 21. Signature of Funeral Service Licenses 107 Vine Street, Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Canca Atho Esophagus Etastatic Immediate Cause (Final disease or condition

Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

ned by the e : After this certifical tuneral director. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

certificate

	resulting in death)	Due to (or as a consequ	ence of):	) '			
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nysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic p			23d. Date of deli Month	very Day Year
<u> </u>	Part II. Other significant conditions o	ontributing to death but not resu	ulting in the underlying o	cause given in Part I.	23e. Did tobacco		the cause of death?
Сощрієєв					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 No
บ	25. Was case referred to medical			26. Place of De	eath (Check only one)		
2	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ D	OA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Spec	cify)
ation;	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, street, factor	y, office	28f. Location (Street City or Town, Sta	and Number or Ru ate)	ural Route Number,
edicai	29a. Certifier (Check only one) Cartifying Ph	nysician: To the best of my kno πiner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	dat the time, date and place, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
š	20h Signature and title of certifier		29	c. License number	29d. [	Date signed (Mont	h, Dey, Year)

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State Registrar 29b. Signature and

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JUL 2 2 2009

31. Date filed (Month, Day, Year)

Vacuza 32. Pegistrar's Signature

ress of person who completed cause of death (Item 23a) (Type, Print)

Camoll Street

_		For State Registrar	State of Maryla		rtificate of l		Re	eg. No.		2000
Physic	cian	1. Decedent's Name (First, Middle, I	•				Date of Death     Month	Day	Year	3. Time of Death
/Med		Barbara Ann Mu					July		2009	3:11 P <sup>M</sup>
Exam	iner	4a. Facility Name (If not institution, guntary Union Hospital				Location of Death		4c. County		
Funera				s. last birthday)	E1kto	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birtho	olace (State or Foreign
Directo		158-30-7497 Usual Residence of Decedent	1□M 2\\ F	70 Yrs.	Months Days	Hours Min.	July 7,		Cour	sylvania
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the M	Director	Maryland Cecil  10e. Street and Number	L   C1	nesapeal	ke City 10f. Zip Code		11	0g. Citizen of	What Cour	
with	٥	30 Park Drive			21915					
death ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp			ce - Americ	an Indian,
and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has a state other than "natural", or items 23a or 28a-f show other traumatic event, it. Madical Evanit at must be mailed	Þ	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		lf Yes, specify Cuba 1 □Yes 2 XINo	n, Mexican, Puerto Specify:	Rican, etc.)		ck, White, o fy: Whit	
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permi Depar impor any ir		21. Sulland of Fulleral Service Lic	O. w.		2. Name and Addres					
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	25 13	shock, or heart failure. List on Immediate Cause (Final	ly on pause on cach line.		•	17.40		500		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Auck	myou	ordiol	interchi	on		_	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	☐ Ectopic pregnanc	<i>y</i>			ate of delive onth	ery Day Year
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g Ph ter th	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Injur Work	y at	28d. Describe ho			,,
ath. r: Af	atio	1 Natural 5 Pending 2 Accident investigati		injury		Yes 2 □No				
Afte er de ecto by th	ific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		home, farm, str	reet, factory, office		28f. Location (St. City or Town		ber or Rura	al Route Number,
s afte	Certification:	T I TOTHICIDE	building, etc. (Spe	City)			City of Town	, State)		
e Hospit 24 hour e Funera	edical (		Physician: To the best of my k aminer: On the basis of exami and manner stated.							
To th withii To th	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signe	ed (Month,	Day, Year)
		Melleur	- Buyar pur		000	62547	_	071	201	200P
		30. Name and address of person wh	no completed cause of death (It	em 23a) (Type.	Print\					
10		KLEWENTY MA BR		sav sh	eet, EILC	ton ND	21821			
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature						
Regis	trar	1111 9	3 2009	B.	parke					
HMH 17 Bev 1	2001	JUL &	O EUO		7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 15 2009 JUL :35 DAWSON REUEL MURPHY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthdav) **Funeral** Months Days Yrs 14, 2009 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be rediffed at 1 ☐ Yes 2 No Funeral Director Maryland Charles Waldorf 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20601 12009 Pierce Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: <u></u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fil h and Mental H 7 is marked oth Teresa Holzbaugh Robert Murphy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health ar Robert & Teresa Murphy/ Parents 12009 Pierce Road, Waldorf, Maryland, 20601 Department of Health Important; If item 27 any injury or other tr once. 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State July 17, 2009 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) **Huntt Crematory** 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service Lice 3035 Old Washington Rd. Waldorf, MD. 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician EXTREME PREMATURITY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Ö 9 Unknown σ. s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 Unknown 1 ☐ Yes 2 🙀 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy performed? 1 ☐Yes 2 ☐No 1 □Yes 2 • No or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2∐XNo 1 X Inpatient 2 ER/Outpatient 3 DOA After this of funeral dire Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: d in by the f 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours a To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar

LEWIS Day, Year)

29b. Signature and title of certifier

USA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

park

29c. License number

0102202176 (VA)

NATIONAL NAVAL

BETHESDA MD 20889-5600

29d. Date signed (Month, Day, Year)

			For State Registrar	State of Ma	aryland		rtment of F rtificate of I		ind Mental Hy	giene Reg. No. 🤍	000	OFOE	
			Decedent's Name (First, Middle, Last		- (				2. Date of De		Year	3. Time of Death	- 8
	Physicia /Medic		John Lloya	MARTZ		DR			July	28	200	2154	И
	Examin	er	4a. Facility Name (If not institution give	1 /2-	TI		4b. City, Town, or	Location of	f Death	4c. Col	unty of Death		
e art. Il	Funeral		5. Social Security Number 6. S		e (In yrs. la	st birthday)	HX303	If Under 2	24 Hrs. 8. Date of Bir		9. Birthp	lace (State or Forei	gn
ı	Director		215-20-8227	X M 2□ F '	83	Yrs.	Months Days	Hours	8. Date of Bir Min. (Month, Da Feb. 9	, 1926	Mar	yland	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limit	ts
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	or 28%	Director	10e. Street and Number				10f. Zip Code			•	of What Coun	itry?	
	s 23a	ıralı	62 Nottingham Roa			1	21740		1000		U.S.A.		_
	ter de iner n	Funeral	11. Marital Status 1 □ Never Married 2 X Married	12. Was Decedent Armed Forces? 1 ∰Yes 2 ☐		. 13. \	Nas Decedent of H f Yes, specify Cuba	an, Mexican,	gin? (Specify Yes or No , Puerto Rican, etc.)	)-   14,	Race - Americ Black, White, e		
036	ours at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1∐Yes 2∏∏No	Specify:		Spe	ecify: Wh	ite	
5	"natu	letec	15. Decedent's Ec (Specify only highest gra			(Give	dent's Usual Occup kind of work done	during most	of working	16b. Kind o	of Business/Inc	dustry	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exeminer must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Machi	00 NOT use retired .nist	u)		Manui	facturi	Ing	
b	e filed al Hygid other vent,	Be C	17. Father's Name (First, Middle, Last)	)				18. Mother	r's Name (First, Middle	, Maiden Sur	name)		
ylaı	should be and Mental s marked c	70	Benjamin Daniel M						Alice Klim				
Mar	alth and 27 is mi		19a. Informant's Name/Relationship ( Betty L. Martz/Wi	• •					r or Rural Route Numb			Code)	
٠,	t and a f Health tem 27 other tra		20a. Method of Disposition		20b. Pla		sition (Name of natory or other place		Hagerstown		$\frac{21740}{\text{on - City or To}}$	wn, State	_
E	Pages nent of I ant: If ite ury or o		1 【 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1 _		en Cemete	i	8/3/2009	Насез	rstown,	MD	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Externing must be notified at once.		21. Signature of Funeral Service Licer	isee (		22	2. Name and Addre	ess of Facility	Rest Have	ı Funer	ral Cha	ipe1	
	ĕO ≣ ≅ O	2 12	On Part Francisco di conse	Me	l the doub				ia Ave., Ha		own, Mi	21742 Approximate	
S	Db	8 13	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.	Do not ent	er the mode or dyn	ng, such as	cardiac or respiratory a	irest,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to dr as	a conseque	ence of):	102	_		1	( >		_
	Examiner		Sequentially list conditions	electiv	e Mi	THOSON	V OF VK	SOPI	Assar + V	entilo	ION		
-	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):	$\cup$	1					
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89 >	ertifica ling ph	Med	if FEMALE:										_
Вох	death certifica attending pl	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome  1  Live birth  4  Pregnant a	2 Fetal	death 3[	Ectopic pregnand Other (specify) _	су		23d	. Date of delive Month	ery Day Year	
P. 0.	uires that the de signed by the a id be detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		, a							
S, F	es thai igned l		Part II. Other significant conditions of	contributing to death b	ut not resul	ting in the u	nderlying cause giv	ven in Part I.				he cause of death?	
ord	requir seen s noutd	sted	suspected Stoph	Seplic S	11CKK	2011	101:		1	Yes 2□N	lo 3□ Prot	bably V Unknow	vn
Division of Vital Records,	ne law has b	Completed by	NONSUSTAINEU (	180181 CO10	/- <i>[k</i>	DCCHU	CRAID		24a. Was	psy	4b. Were auto prior to co death?	psy findings availat mpletion of cause o	ile if
<u>a</u>	an; Th tificate or, pag		25. Was case referred to medical					26 Place	1 ☐ Yes	ormed? 2 Z No	1 ☐ Yes	2 No	
Ę	nystcia nis cer direct	o Be	examiner? 1 🗆 Yes 2 No	Hospital: 1 Inpati	ent 2 🗆 E	R/Outpatier	nt 3 DOA Oth	or:	rsing Home 5 Res		Other (Special	fy)	_
o L	Ing Pt	on:	27 Manner of Death  Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	Wor	k?	28d. Describe	how injury oc	ccurred		
isio	ttend death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	e lana of Ini	ury . At hor	ne farm str	M 1 □ eet, factory, office	Yes 2□N		(Street and N	lumber or Rum	al Route Number,	
<u>.≥</u>	al or A s after I Direct d in by	Certification: To	4 ☐ Homicide determined	building, et	c. (Specify)	)	oct, ractory, emoc		City or To	wn, State)	amoor or mare	ar roate rames,	
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a								d place, and due to the				
	the H thin 24 the F mplete	Medical	one) 29b. Signature and title of certifier	and manner st			29c. Licens				igned (Month,		
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			30. Name and address of person who		eath (Item	23a) (Type,		1,		1/0	1		_
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Amend \$\frac{1}{2} \text{18} \text{ per Inf C894 8/17/09 TT The all the Black Indelible Ink. Ensure All Copies Are Legible.

Amend \$\frac{1}{2} \text{18} \text{ Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No, Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:44 P M July 28, 2009 Sylvia Rose Murray /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carrol1 Sykesville Transition Health Care If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth 07-09-1922 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Hours **Funeral** Months Pennsylvania 1 M 2 F 87 Yrs 168-14-7477 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Wedical Examiner must be notified at MD Carroll Westminister 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 21157 10e. Street and Number USA 2428 Raintree Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. Specify: ò 3 ☐ Widowed 4 🏋 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk Clerical nd 2 should be filed wath and Mental Hygie 27 is marked other tlraumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Sylvia** Cupfender Walter S. Gartside 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important: If item 27 is r any injury or other traur 2428 Raintree Ave., Westminister, MAryland 21157 (Daughter) Sharon Everett 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-31-09 Chambersburg, PA. Salem Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Thomas L. Geisel Funeral Home MO1346 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 17202 Immediate Cause (Final disease or condition resulting in death) Dementin hysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to invite a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) o cate has been signed by the page 2 should be detached 9 Duknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown HTW Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Disor dev certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 □Yes 2 DNO funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 12 1√1√10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No spital or Attendi nours after death. neral Director: A investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7-29-09 230119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYRESVILLE MD 21784 ROAD 1010012 ACHAH2 821L y KESVILLE 32 Registrar's Signature

DHMH 17 Rev 1/2001 5

State Registrar 31. Date filed (Menth Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month NELL 20 Mor Phis 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard Columbia Howard County General Hospital Birthplace (State or Foreign Country) TSZ If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours (Month, Day, Year) 9/10/1921 1 □ M 2 🔀 F NY 066-16-8310 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Ellicott City 1 ☐ Yes 2 No Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 5330 Dorsey Hall Dr. #210 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Executive Administrative Asst. Public Relations 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Joannides John Psaroudis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4702 Bounty Ct., Ellicott City, MD 21043 Katherine McCullough / Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, MD 7/22/2009 Ardent Cremation 4 ☐ Donation > ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature uneral Se viee Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death?

the Hospital or Attending Physiclan: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the aid be detached <u>۾</u> Completed s certificate has t lirector, page 2 sl Be Certification: To After 1 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

r items 23a or 28a-f shoviling at

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or itel ury or other traumatic event, the Medical Exercitival

permit. Pages 1 Department of H Important: If ite any injury or ol once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with the

Director

Funeral

Completed by

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Fattii. Other significant conditions	Continuing to death but not receiving in the discounting cause growth.	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No  24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Manner of Death 1	(Month, Day, Year) Injury Work?	8d. Describe how injury occurred
3 Suicide 6 Could not 4 Homicide determine		8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	and due to the cause(s) and manner as stated.  It is a stated and at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

29d. Date signed (Month, Day, Year)

D30641 July 2, 2009

Neck Moad Balh mave Mayland 21221

Medical

29b. Signature and title of certifier

31. Date filed (Month

(1)00

P.O. Box 68760.

Records.

State Registrar

DHMH 17 Rev 1/2001

MD

Suple

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29c. License number

00053150

Sanhago Rd

29d. Date signed (Month, Day, Year)

lor Attending Physician: The law requires that the death certificate be executed after death. Box 68760, P.0. Division of Vital Records, certificate hours after death.

neral Director: After this y filled in by the funeral di

Be

Certification: To

Medical

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

25. Was case referred to medical examiner? 1∐ Yes 2 No 27. Manner of Death

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Natural 5 Pending investigation 2 Accident 3 Suicide

29a. Certifier

(Check only one)

28a. Date of Injury (Month, Day, Year) Injury 1 ☐ Yes 2 ☐ No

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

1 ☐ Yes

2 12 No

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Jameka Riley, P.A. 2001 Medical Parkway Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Registrar's Signature

JUL 21

Registrar

24 hours a Hospital

To the within 2 To the I

	-	For State Registrar	State of Maryl		artment of He <i>rtificate of D</i> e			Reg. No. 2009	25062
		1. Decedent's Name (First, Middle, Las	t)			Ĭ	2. Date of Dea	ath Day Year	3. Time of Death
Physici /Medio		Jeffrey M. Pancu					July	21 2009	
Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Lo			4c. County of De	
		Northwest Hospit 5. Social Security Number 6. S		yrs. last birthday)		If Under 24 Hrs.	8. Date of Birti (Month, Day	Baltimo	irthplace (State or Foreign
Funeral Director			<b>⊠</b> м 2□ F 5	5 Yrs.	Months Days	Hours Min.	09/11/	1953	PA
pu .		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
taryla f shov	ō	, sai state		Baltim	1 ∐Yes 2 <mark>M</mark> gNo				
the N 28a-i	rect	MD Baltim  10e. Street and Number	ore		10f. Zip Code			10g. Citizen of What 0	Country?
3a or	Funeral Director	1909 Cross Trail	s Road		21244		1	United Sta	tes
death	ner	11. Marital Status	12. Was Decedent Ever i	in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Orlgin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, Wh	nerican Indian, nite, etc.
partition (e), Interpretation 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event in at most be notified at any injury or other traumatic event, the Medical Event in at most be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Event in at most be notified at any once.	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:			Specify:			White
2 hou		15 Decedent's Fo	lucation	16a. Dece	edent's Usual Occupati	ion ring most of worki	ina I	16b. Kind of Busines	ss/Industry
thin 7. The san "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	ring moot of mornin	9	Educati	On
led wi Hygier Hyer th	ပ်	17. Father's Name (First, Middle, Last,	4		Teacher	18. Mother's Name	e (First, Middle,	Maiden Surname)	011
d be file ental H ced oth	Be	John Pancurak					y Cente		
should should nd Me mark mark imatic	۴	19a, Informant's Name/Relationship (	Type. Print)	19b. Mail	ing Address (Street ar			er, City or Town, State	e, Zip Code)
ind 2 stath a strau		Karen Pancurak -	wife				Baltim	ore, MD 21	
es 1a of He of He rothe		20a. Method of Disposition  ★□ Burial 2 □ Cremation 3 □	Pomoval from State	Ob. Place of Disp cemetery, cre	osition (Name of matory or other place)		Date	20c. Location - City	
Pag ment tant: h		4 ☐ Donation 5 ☐ Other (Specif	(y) G		leaven Cem.			Silver Sp	
Dallillo permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Lices	nsee MO14						amily F.H.Inc y, MD 21043
		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		ace Am	ML DISEM	KF			Onset and Death
/Medical		resulting in death)	Due to (or as a co						
Examiner	<u></u>	Sequentially list conditions,	b. Due to (or as a co		PHROPAL	HY			
ted 1sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	nsequence or):					
execu n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):					
ob / ou, ficate be executed physician and s the burial-transit	dical		d						
contificating phases as the		IF FEMALE:							
COrds, P.O. BOX of wrequires that the death certification is great signed by the attending I should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	Day Year
the de	ysic	1 □Yes 2 □ No 9 □ Unknown	9 Unknown	e or death 5					
requires that the seen signed by the hould be detached		Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause give	n in Part I.	23e. Did	tobacco use contribut	e to the cause of death?
guires quires en sig uld be	ed by	Acuto Cardiopi	Amonay A	most			1 🗆	Yes 2 No 3 □	Probably 4 Unknown
ecords, law requires t as been signe 2 should be o	Completed	Insulin Depend	lent Piabs	tes Me	silins		24a. Was	psy prior	autopsy findings available to completion of cause of
The ate h	Som	/					1 □Yes	ormed? death 2 No 1 □	Yes 2 No
OT VITAI HEC Physician: The law this certificate has tral director, page 2 sf	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dea		one) sidence 6 ☑Other	PASONS HOSPICE
Phy Phy Part of a land of the	l.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient	2 ☐ ER/Outpati 28b. Time	of 28c. Injury			how injury occurred	Specity)
lon of	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ear) Injury		? /es 2 □ No			
DIVISION OF To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d	Certification: T	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		At home, farm, s Specify)	street, factory, office		28f. Location City or To	(Street and Number o	r Rural Route Number,
spital o		29a, Certifier 1 Certifying P	hysician: To the best of m	ny knowledge, de	ath occurred at the tim	ne, date and place	e, and due to the	e cause(s) and manne	er as stated.
n 24 h n 24 h he Fur pletely	Medical	(Check only 2 Medical Exa	iminer: On the basis of ex and manner stated	amination and/or	investigation, in my or	pinion, death occu	irred at the time		
To the within 2	Ž	29b. Signature and title of certifier	RIT		29c. License			29d. Date signed (M	nonth, Day, Year)
		PARI WILLIAM	surun			45931		0017	61 600 1
(29,2		30. Name and address of person who	completed cause of death	n (Item 23a) (Type	e, Print)	SINDE 71	93 R	21hmms	80212 CM
S	tate	31. Date filed (Month Pri Year)	2000 32. Jegistrar's			JUITE LE	· · · · ·	1 1	0
Regis		JUL 23	CUUS Cherry	1 B. K	parke				

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 LEN 0205 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchest General HOSPital Combridge Dorches If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X** M 2□ F Director MARYLAND 220-28-0623 05-11-1931 78 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2 No Director DORCHESTER **CRAPO** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2465 ANDREWS ROAD 21626 U.S.A. death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 No Specify: WHITE 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEAVY EQUIPMENT OPERATOR COUNTY ROADS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental pe permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item Z7 is marked any Injury or other traumatic evonce. MARGARET LOUISE CAREY GEORGE ALLEN PRAHL ၉ Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY J. PRAHL/SON 4163 WHITELEYSVILLE ROAD, HURLOCK, MD 21643 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OXFORD CEMETERY 07-21-2009 OXFORD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac of respiratory arrest.

MARYLAND 21601

Immediate Cause (Fine) Immediate Cause (Final Physician EMPHYSEMF disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HEART CONGESTIVE sequentially life conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed PNEUMONI and the burial-tran Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has, 24a. Was an page 2 autopsy this certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1☐Yes 2☑No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the f 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day,

Abul

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year!

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Registrar's Signature,

29c. License number

29d. Date signed (Month, Day, Year)

Washington St. Easter, MU 21601

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician PROCTOR TR JULY HARLIE 20 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner PRINCE SOUTHERN MARYLAND HOSPITAL GEORGES INTON If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Min **№** M 2□ F Months Davs Hours 256-68-8679 63 GEORGIA Director 12-16-1945 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No MD PRINCE GEORGES DISTRICT HEIGHTS Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code death with ò 20743 USA or items 23a 2122 County Road #T2 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Marter once. Art Design Bill Elementary/Secondary (0-12) College (1-4or 5+) Ceramis Tile Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Charlie Proctor Sr. Clara Mae Tavlor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Proctor/ WIFE 2122 County Road #T2 District Heights,MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 7-29-2009 Landover, MD Warmony Memorial Name and Address of FacilityJohn T RHines Funeral Home LLC 21. Signature of Funeral Servix Licenses Juan Smith  $\sqrt{3005}$  12th St NE Washington, DC 20017 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed HYPOXIA and burial-trar Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical () BSTRUCTI attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy 1 ☐ Yes 2 100 1 TYes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie of death (Item 23a) (Type, Print) SURRATTS State JUL 2 3 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 🖺 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Steven Aaron Russell 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (01 Peninsula Peaional Medical Center 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day Year) Social Security Number **Funeral** 1**X** M 2□ F 56 Months DE 214-60-9849 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10h. County show "natural", or items 23a or 28a-f showed as a contract of the second of the contract of the con 1 ☐ Yes 2 X No Director Temperance ville Accomack 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23442 USA 25000 Messongo Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify: Specify: white δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, Ir. Made once. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph W. Russell Doris Powell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25000 Messongo Rd., Temperanceville, VA 23442 Barbara Russell / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/22/2009 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 2181 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AUCUA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the death certificate be executed and I-trar that initiated events resulting in death) Last Due to (or as a consequence of): -burialphysician Box 68760 Physician/Medical as the the attending IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year jo 5 ☐ Other (specify) Tyes 2 No P.0. be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 1XYes 2 No Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death al or Attending P after death. 5 Pending investigation 1 🗹 Natural 1 □Yes 2 □ No 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide Hospital of 24 hours at Euneral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and 09 of person who completed cause of death (Item 23a) (Type, Print) Name and address DN 4 100 E SAlisbury md. 21801 arroll St. Myder 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

		1- State of Maryland /	Department of F Certificate of			iene g. No.	09 25066
Physici	ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day 2009	Yeer 3. Time of Death
/Medie		ERVIN ALEXANDER RANSOME  4e. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death	200421	4c. County	of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last 220-17-2698 12 F 31		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3 – 25 – 1		9. Birthplece (State or Foreign Country) MD •
		Usual Residence of Decedent					10d. Inside City Limits
show	٥	10a. State 10b. County 10c. City, To	own or Location  LA PLATA				1X Yes 2 No
the A	Director	10e. Street and Number	10f. Zip Code		10	0g. Citizen of V	Vhat Country?
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ised within 72 hours after death with the Maryland Hygiene. Whysiene. Wher than "natural", or items 23a or 28a-f show one. It a Medical Examinat naul by medified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes, Give Year or Dates:	13. Was Decedent of Hif Yes, specify Cubin 1 Yes No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Blac	e - Americen Indian, k, White, etc. BLACK
"nsturs!; or			6a. Decedent's Usual Occup	pation	ing	16b. Kind of Bu	usiness/Industry
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	To B	GEORGE E. RANSOME		CYNTH	A IREN	E MATI	HEWS
Mally fall (C. L. L. L. L. L. L. L. L. L. L. L. L. L.	ľ		19b. Mailing Address (Street				
thea t		20a. Method of Disposition 1 Description 2 □ Cremation 3 □ Removal from State  20b. Place SACCH SACCH	633 HEMLOCK of of Disposition (Name of Stary, crematory or other plants of CED HEART C				City or Town, State
Deficility  permit. Pages Department of Important: If It any injury or o		1. Signature of Furieral Service Licensee M00479	RAYMOND	FUNERAL	SERVIC	E,P.A.	
		23a. Part1. Enter the diseese, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	LA PLATA Do not enter the mode of dying	MD 206	or respiratory arre	est,	Approximate Interval Between
Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequen	Wound +	o Abdo	omen		Onset and Death
cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)  Due to (or as a consequence)					
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal detection of the past 12 months?	eath 3 Ectopic pregnanc	у			te of delivery
that the deed by the a	iysic	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death	h 5 ☐ Other (specify) _				
quires that it n signed by	b	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause gr	ven in Part I.	23e. Did tol		ribute to the cause of death?  3 Probably 4 Unknown
sicien: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Completed				24a. Was a autops perform	med?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
ysicien: The sectificate director, pag	Be	25. Was case referred to medical	* 10		th (Check only on	(8)	
ding Phys	Certification; To		35. Time of linjury Wo	ry at		treet and Numb	77 40
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Cer	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowle and manner stated.	edge, death occurred at the transfer investigation, in my	ime, date and place opinion, death occu	and due to the c	ause(s) and ma	anner as stated.
To the within of Fo the comple	Mec	29b. Signature and title of certifier	29c. Licen			•	d (Month, Day, Year)
		I falorde Blasto	go the	005597	7 2	Jul 3	20 2009
		30. Name and address of person who completed cause of death (Item 23	3a) (Type, Print) uspital Z	005597 Drive (	cheve	cla,	Mayland
St Regist	tate trar	SSLVA der Synther 304 H  31. Date filed (Month, Day, Year)  ALIG 05 2009  Stewn 9	barrel			11	,

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lightry or other traumatic event, the Modical Examinar must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	For State of I	Maryland / De					0 /	200	0 = 0 6 =			
	Registrar  1. Decedent's Name (First, Middle, Last)		<i>Jeruncai</i>	e of Deat		2. Date of Deat	eg. No.		3. Time of Death			
ın						Month	Day	Year				
al	Matilda N. Reid  4a. Facility Name (If not institution, give street and numb	er)	4h Cihu	Town, or Location	on of Dea		29, 2 4c. Count	009	1:45P M			
er	807 Petem Road	017					Harf					
		Age (In yrs. last birthe	day) If Unde		er 24 Hrs	s. 8. Date of Birth		9. Birthp	lace (State or Foreign			
	216-16-3453 <sup>1□ M 2</sup> XF	85 Yr	Months	Days Hou	s Min	May 6,	1924	Mary	vland			
	Usual Residence of Decedent											
_	10a. State 10b. County	10c. City, Town of						10	0d. Inside City Limits			
ectc	Maryland Harford	Kingsvi							1 □Yes 2 No			
Ē	10e. Street and Number		10f. Zip				0g. Citizen of		try?			
eral	807 Petem Road  11. Marital Status 12. Was Decede	- LE		087	0::0/		U.S.A					
Ä	11. Marital Status 12. Was Decede Armed Force 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 25	s?	If Yes, spe	cify Cuban, Mexi	can, Pue	Specify Yes or No- rto Rican, etc.)		ce - America ck, White, e				
þ	If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Date		1 □Yes	2 No Spec	ify:		Specia	<sup>y:</sup> Whit	te			
Completed by Funeral Director	15. Decedent's Education	16a. D	ecedent's Usu	al Occupation			16b. Kind of E	Business/Ind	dustry			
ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4-		Give kind of wo ife. DO NOT u	rk done during n se retired)	nost of wo	orking						
Son	12	Hon	nemake	r			Own H	ome				
Be (	17. Father's Name (First, Middle, Last)					ame (First, Middle, I		me)				
	Joseph Novotny			Ka	ther	rine Ber	an					
	19a. Informant's Name/Relationship (Type. Print)			•		Rural Route Number			*			
	Joseph P.Reid, Sr./Son			<u>.</u>	King	gsville,						
	20a. Method of Disposition  1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	te 20b. Place of D	rematory or o	me of other place)	1		20c. Location	•				
	4 Donation 5 Dother (Specify)	Parkwo	od Ce	metery		<u>_</u>			Maryland			
	21. Signature of Funeral Service Licensee  MCGGL Manual Property Communication (Communication)			arford	ĬΑ				Chapel,P.A Land 21214			
	23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only or e cause on eac	sed the death. Do no						1417	Approximate Interval Between Oriset and Death			
			1 ria	ht 1100	200	Inheli	in a	AUSCH	Orset and Death			
		Immediate Cause (Final disease or condition resulting in death)  Table 10 (or as a consequence of):  Due to (or as a consequence of):										
	Sequentially list conditions, b.											
ine	if any, leading to immediate ause. Enter Underlying Cause (Disease or injury	as a consequence of)	:									
Examiner	that initiated events c.	as a consequence of)										
	Due to (or	as a consequence of	•									
Completed by Physician/Medical	d											
J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outco	me of pregnancy					23d D	ate of delive	erv			
iciai	in the past 12 months?	h 2□Fetal death nt at time of death	3 Ctopic   5 Other (s					onth	Day Year			
hys	9 ☐ Unknown 9 ☐ Unknow	'n										
γP	Part II. Other significant conditions contributing to deat	h but not resulting in t	he underlying o	ause given in Pa	art I.	23e. Did tol	bacco use cor	ntribute to th	ne cause of death?			
ed		-				. 120	es 2 No	3 ☐ Prob	ably 4 Unknown			
plet						24a. Was a	n 24b.	Were auto	psy findings available mpletion of cause of			
E O						perform	ned? 2 No	death?	2 No			
Be (	25. Was case referred to medical examiner?			26. P	ace of De	eath (Check only on	/					
	1 ☐ Yes 2 No Hospital: 1 ☐ Inp	<del></del>	atient 3 D		Nursing		ence 6 □Ot		y)			
on	Tradulal S   Cliding	Injury 28b. Tir <i>Day, Year)</i> Inji		28c. Injury at Work?		28d. Describe ho	ow injury occu	rred				
icat	2   Accident investigation   3   Suicide   6   Could not be   280   Bloom of	Injury At home form	M	1 ☐ Yes 2	□No	206 Lengtion (C		D	d Davida Maraham			
4 Homicide determined determined determined building, etc. (Specify)  29a. Certifier (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								ir Houle Mulliber,				
								stated. the cause(s)				
Mec	29b. Signature and title of certifier	sialeu.	29	c. License numb	er	2	9d. Date sign	ed (Month.	Day, Yearl			
	Frency Hus	die n	7	D36	05	14	7/	30	109			
	30. Name and address of person who completed cause	of death (Item 23a) (I	ype, Print)	TOW	50	am, n	2120	4	•			
е		istrar's Signature	0			*						
ir	AUG 05 2009	news A.	25 Jan Al	1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sir.

Sta

		1 – For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F ertificate of t			ene 3. No. O O O	10 25068
Physic		Decedent's Name (First, Middle, Last	,	)k Suh			2. Date of Death Month <b>July</b>		3. Time of Death  4:40 pM
/Med Exami		4a. Facility Name (If not institution, giv	street and numi	ber)		Location of Deat		4c. County of	
Funera Directo		5. Social Security Number 6. S		. Age (In yrs. last birthday				Year) 9	Birthplace (State or Foreign Country)  South Korea
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo	mory	10c. City, Town or L		1			10d. Inside City Limits 1 ☐ Yes 2 <b>X</b> No
with the	I Director	10e. Street and Number  13024 St. Clair			10f. Zip Code	larksburg	10	g. Citizen of Wha	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment was the natified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Force 1  Yes 2 If Yes, Give Year or Dat	es?	. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	20871 lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		U.S.A. American Indian, White, etc.  Asian
21215-0036 d within 72 hours aft gleine. er than "natural", or ine Medicel Everni	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occup e kind of work done o DO NOT use retired Self-Emplo	during most of wo		6b. Kind of Busir	
land 2 Id be filed ental Hyg ked other ic event,	To Be C	17. Father's Name (First, Middle, Last)	Ukn				me (First, Middle, M.		Ukn
Maryland od 2 should be file tith and Mental Hy 27 Is marked oth	F	19a. Informant's Name/Relationship (  Song Suh - Daughter			,		ural Route Number,	,	. =
Baltimore, permit. Pages 1 an Department of Hea mportant: If Item 2 mny injury or other		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ □ Other (Specif	Removal from St	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place	ce)		0c. Location - Cit	y or Town, State
Balti permit. Departh Importa any Inju		21. Signatu e if Fun ital Service Licer		de la companya de la	22. Name and Addre	ss of Facility <b>i. Funeral</b>	Home, Inc.		Maryland 20904
ficate be executed by sician Physician and burial-transit sthe burial-transit		23a. Part 1. Enler the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the conditions of the cause (Disease or injury that initiated events resulting in death) Last	one cause on each a. a. Hepat Due to (o b. Due to (o c.			ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death  17 months
Geath certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live bir	int at time of death 5	☐ Ectopic pregnanc	у		23d. Date of Month	,
rds, P.  puires that to a signed by lid be detact	b	Part II. Other significant conditions of	ontributing to dea	th but not resulting in the	underlying cause giv	en in Part I.			ute to the cause of death?
Vital Records, P.O iclan: The law requires that the certificate has been signed by th ector, page 2 should be detache	Completed						24a. Was an autopsy perform 1  ☐ Yes 2	ed? prid	re autopsy findings available or to completion of cause of hth? IYes 2 □ No
Of Phys Phys rathis	Certification: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation	28a. Date of (Month	patient 2 ER/Outpatie Injury 28b. Time Injury Injury	of 28c. Injur Worl	er: 4 □ Nursing H y at	ath (Check only one Home 5 🖾 Resider 28d. Describe how	nce 6 Other	(Specify)
Division all or Attending s after death. al Director: Afte	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o	f Injury - At home, farm, s g, etc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical (			nest of my knowledge, dea sis of examination and/or or stated.					
To the To the comple	Ž	29b. Signature and title of certifier	04.0		29c. Licens	e number MD060335		d. Date signed (i	Month, Day, Year)
		30. Name and address of person who Paul Bannen, M.D.,	9901 Medi	cal Center Driv	ve, Rockvill				, 2003
St Regis	ate trar	31. Date filed Month, Day, Year)	9 Center	pistrar's Signature	New York				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jean Marie Sanislo Ju1v 18 2009 12:05 P <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kris Leigh Assisted Living Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2**K**X Days Yrs. 91 Sept. 1917 Connecticut 046-01-6253 8, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 329 Martins Cove Road 21409 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2x XNo If Yes, Give Year or Dates: 1 □Yes 2\1\2\No Specify: Completed by Specify: White 3₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Finance Department Engineering/Optics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cornelius McNally Clara Natteford မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 329 Martins Cove Road Annapolis, Maryland Linda Gregory/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 7/20/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 70 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Years onacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due the (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 No 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician for use as the buria ned by the a signed by t d be detach

Box 68760.

Division of Vital Records.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marked of the manual phase notified at once.

Baltimore, Maryland 21215-0036

E

After this certificate has been si funeral director, page 2 should I

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

determined

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peninsula

Ramona & Soidel 269 TD

31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

within 24 hours after death. To the Funeral Director; A

Hospital

the

filled in by

completely

			1 - For State Registrar	State of N	1arylan		artmen rtificat			and M		giene	2009	2507	
П	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time										3. Time of Death		
	/Medic Examin	cal	John Pershing Smith II								July		2009	2:40 P M	
		ner	4a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death  Elkton				4c. County of Death  Cecil			
			Union Hospital  5. Social Security Number 6. Se		Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birt (Month, Da	h		place (State or Foreign	
	Director		218-76-4098	X M 2□ F		35 Yrs.	Months	Days	Hours	Min.	Nov. 9	, 197	3	Maryland	
	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show leafted Ever in ser must be rediffed at		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits	
		to	Maryland Cecil			Rising	Sun							1 ∐Yes 2X No	
	or 28g	Director	10e. Street and Number			aroing.	10f. Zip	Code	-			10g. Citizer	of What Cour	ntry?	
	ath wi	ral	68 Towers Lane				21911						USA		
	items	Funeral	11. Marital Status	11. Marital Status  1 □ Never Married 2 ☑ Married  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No			J.S. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto					ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.			
5-0036	urs af	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:				1 □Yes 2 ☑ No Specify:					Sp	Specify: White		
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א ס	2 should be filed and Mental Hy, is marked othe aumatic event,	Be Co	12 17. Father's Name (First, Middle, Last)			FILE	Ignic	1 1		-	(First, Middle,			100	
yland		To B	David Pershing	Smith					Dar	lis A	Ann McC	ardel	1		
Mar			19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	r, City or To	wn, State, Zip	Code)	
e Ge	and and and and and and and and and and		Mary Smith/Wife		00h B						g Sun,		1911 ion - City or To	Chate Chate	
	iit. Pages artment of I		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □		е	lace of Dispo emetery, cren			i				•		
altimor	permit. Pa Departme Important any Injury once.		4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service License		Bro	ookvie	w Cem			/-25- v	2009	Risin	g Sun,	Maryland	
ñ			Dichard L	and	1 .		R.T.	Foar	d Fui	neral	l Home, Rising	P.A.	MD 21	911	
)	To the propriate of Attending Prystolan: The law requires that the death certificate be executed to within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and the completely filled in by the funeral director, page 2 should be detached for use as the burial-transit to be a burial-transit.	Physician/Medical Examiner	23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cluse on each line.  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
. O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic p		,			230	. Date of delive	ery Day Year	
Š,	res tha	þ	Part II. Other significant conditions contributing to death but not resulting in the un					nderlying cause given in Part I.				23e. Did tobacco use contribute to the cause of death?			
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Ĕ		Completed	Neutro penu fever									24a. Was an autopsy performed?  ↑ ☐ Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?  ↑ ☐ Yes 2 ☐ No			
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5	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. Or the Funerial Director: After this certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use as	မ	1 Yes 2 No	t 3 DC						fy)					
5		tion	27. Manner of Death  1 Matural  2 Accident  3 Sulcide  4 Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28b. Time of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Place of Injury 28b. Time of Injury 2b. Time of Injury 2b. Time of Inju					28c. Injury at Work?  M 1 □ Yes 2 □ No			28d. Describe how injury occurred				
IVISIOII		Certification:						et, factory, office 28f. Location				n (Street and Number or Rural Route Number, Town, State)			
ב	pital c														
	within 24 ho To the Fun completely	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
			29b. Signature and title of certifler					29c. License number				29d. Date signed (Month, Day, Year)			
			Kerry Lei	my Ph	ysiar	in	7	6	904	8		7/22	109		
			30. Name and address of person who c		death (Item	23a) (Type,						-			
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signal	ture	CIKH	211	MI	21	921				
	Registr			000		A. 4	backs								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 6:55 P <sup>M</sup> 7-30-2009 George Maynard Summers /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Northampton Manor Health Care Frederick 8. Date of Birth (Month, Day, Year) 12-30-1908 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 X M 2 □ F MD 220-16-3554 100 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the Madeal Experimental be notified at 1 ☐ Yes 2 No Funeral Director MD Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 B Catoctin Avenue 21701 **USA** 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Year or Dates: 41–44 Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important; If item 27 is marked other the any injury or other traumatic event Vending Company Sole Proprietor 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Lillie Belle Castle George Samuel Summers ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wife 1 B Catoctin Avenue Frederick, MD 21701 Mary Elizabeth Summers 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-4-2009 Mount Olivet Cem. Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Line need M01176 106 East CHurch Street Frederick, MD 21701 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impulate Cause (Final disease or condition resulting in death) 2 Days Physician ongesti Ve /Medical Due to (or as a sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2. No 1 ☐ Yes Blodder 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) AUG 0 5 2009

29b. Signature

Name and ad

Ihomas Registrar's Signature

person who completed cause of death (item 23a) (Type, Print)

Johnson Dr. Frederick, MD 21702 Darkas

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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## VOID

# CERTIFICATE #

2009-25072

## SEE

CERTIFICATE #

2009 - 27868

**Physician** /Medical Examiner

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Completed by

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Certification: To

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

permit. Page Department o Important: If any Injury or once.

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f show

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Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. In: If item 27 is marked other than "natural", or ite iny or other traumatic event, the Madical Exercise iny or other traumatic event, the Madical Exercise.

Baltimore, Maryland 21215-0036

Director

Funeral

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> Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

CEREBROVASCULAR

ACCIDENT

1 Yes 2 No 3 Probably 4 Unknown

DEMENTIA

24a. Was an autopsy 1 ☐Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Hospital:

1 ☐ Inpatient 2 ►ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐Yes 2 ☐No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of ertifier

M.D

29c. License number D0063978 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED, M.D., 7525 GREENWAY CTR DRIVE,

GREENBELT MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05456 Jennifer Leeanne Thompson State of Maryland / Department of Health and Mental Hygiene 25074 1. For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day July 12, 2009 1420 hrs Medical Examiner Jennifer LeeAnn Thompson 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 10 Whitehall Circle Cecil Fiktor 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Mary land Months Days Hours Min Director 215-06-5554 2X F 25 08/18/1982 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location any 10a. State 10b. County 1 Yes 2 X No 28a-f show MD Cecil E1kton hours after death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 21921 10 Whitehall Circle United States 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status

1 X Never Married 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Armed Forces 2 Yes Specify: White 0 2 X No specify: Widowed Divorce Yes Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) pernit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Student School 3 4 1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ronald Lee Thompson Shelley Marie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n traumatic 16006 Letcher Rd.Brandywine, MD. 20613 Ronald Lee Thompson / Father 20a. Method of Disposition

1 Burial 2 X Cremation 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) JUly 16, 2009 Donation 5 Huntt Crematory \_Waldorf, MD. Other Specify Signature of Funeral Service License 22. Name and Address of Facility Huntt Funeral Home MØII 3035 Old Washington Rd. Waldorf. MD. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death a, Multiple Injuries Immediate Cause (Final disease :aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED by the attending physician iched for use as the burial Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth 2 V Fetal death Month Day Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b ≥ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed has been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? icate 1 Yes 2 V Yes No certific To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medica 26.Place of Death (Check only one) æ examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 ✔ Other: Scene DOA this Inpatient 2 ER/Outpatient 3 10 1 Yes No 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject assaulted FOLIND: Natural Yes 2 V No Director: Pending Jul 12, 2009 1230 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 10 Whitehall Circle, Elkton, MD determined (Specify) Single Family Residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME. July 13, 2009 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year Registrar's Signature State alle

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland		rtificate of L			g. No. 2 A A	25075
	Physicia		1. Decedent's Name (First, Middle, Last)  Mary Lush Weat	ver	,			2. Date of Death	Day 200 9	3. Time of Death
*Bage	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
			Washington County				stown		Washing	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) Yrs,	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 25,	Year) Co	thplace (State or Foreign buntry) <b>rqinia</b>
	Director		230-01-5015 Usual Residence of Decedent	••				Dec.25,	1010 VI	
	show	ř	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he Ma 28a-f	Director	Md. Washing	gton S	Smiths.	burg 10f. Zip Code			og. Citizen of What Co	- 21
	3a or	E D	12630 Bradbury A	Ave.			.783		U.S.A	,
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exeminer must be notified at	Funeral	11. Walta Glalas	Was Decedent Ever in U.S Armed Forces?	i. 13. \	Nas Decedent of H f Yes, specify Cuba	Ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by Fi	1 ☐ Never Married 21 Married 3 ☐ Widowed 4 ☐ Divorced	1		l∐Yes 2 <b>½</b> ∏No	Specify:		Specify:	White
9-0	2 hou	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business	
21215-0036	ithin 7 ne. <b>"nan "r</b>	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	ning of work doine to DO NOT use retired Homemake1	)	ang .	Ноп	ne.
d 21	filed w Hygie ther tl		17. Father's Name (First, Middle, Last)			110Memare1	18. Mother's Name	e (First, Middle, N		
lan	Ald be Alental Arked o	To Be	Robert Lee Wel	lls Sr.			Patti	e Archer	Dearn	
Maryland	2 shour and Name		19a. Informant's Name/Relationship (Typ		1	-			City or Town, State,	
e, N	1 and Health em 27 ither t	1	Gerald M. Weaver  20a. Method of Disposition	20h Pl	ace of Disno	sition (Name of		Date 2	,Md. 21783 20c. Location - City or	
altimore,	Pages lent of nt; If it ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Smi	emetery, crer thsbur	natory or other place g Cremato	e) Aug.	Ι,	Smithsbur	g,Md.
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experience rust to nutified an once.		21. Signature of Funeral Service License	Davis MO14.		2. Name and Addres			25 Bradbur thsburg,Md	
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death						Approximate Interval Between
4	Physician	0.0	Immediate Cause (Final disease or condition	Pren	non	7				Onset and Death  3 www.
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):	u-AS F	30110			3 woman
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	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			tic a	acto Va	rator 1	Dinun	7~
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Вох	eath certifi attending for use as	Physician/M	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		☐ Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
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Vita	sician certif irector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	EB/Outnotic	ot 3 🗆 DOA Oth	er:		ence 6 ☐ Other (Sp.	agifu)
1 0	g Phy ter this neral d	n:To	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time o		v at		ow injury occurred	вопу)
sior	tendin eath. or: Af the fur	catio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1□	Yes 2 □No			
Division	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, sti	eet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Houte Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my knoner: On the basis of examina and manner stated.	wledge, deat	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	, and due to the or rred at the time, d	cause(s) and manner a late and place, and du	as stated. ue to the cause(s)
	To the within To the comple	Mec	29b. Signature and title of certifier			29c. Licens	se number		9d. Date signed (Mor	
	1 0		· catt ~	0		DI	8019		JULY 30	2009
			30. Name and address of person who co			Print)	7 HA	KERSTI	ow~ ~	0 21748
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		0 0				

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			State of Maryland  - State Registrar		tificate of D			g. No. 2 ()	09	250	176
ì	Physicia		1. Decedent's Name (First, Middle, Last)  Paul Webb				2. Date of Death Month July	Day	Year 009	3. Time of D 10:35	P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	T	4b. City, Town, or	Location of Death		4c. County of	of Death		1
	Funeral Director		Kline House  5. Social Security Number  5. Social Security Number  6. Sex 1  M 2  F  7. Age (In yrs. las	t birthday) Yrs.	Mt. A If Under 1 Year Months Days	iry If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2	Year)	Coun	ace (State or	Foreign
	 '0		Usual Residence of Decedent	Town or Los	- diag		IIPIZI Z	1 2 2 2 3		Od. Inside City	/ Limits
	Marylar -f show	tor	Tour state	Town or Loc  deric						1 □Yes }	
	vith the	Director	MD Frederick Fre  10e. Street and Number	delic	10f. Zip Code			og. Citizen of W	hat Coun	try?	
	ns 23	Funeral	5955 Quinn Orchard Rd  11. Marital Status 12. Was Decedent Ever in U.S.	13. V	2170 Vas Decedent of Hi f Yes, specify Cuba				e - Americ	an Indian,	
036	urs after o al", or iter Examiner	by	Armed Forces?  1 □ Never Married 2 □ Marrled  1 □ Never Married 2 □ Marrled  1 □ Yes 2 □ No		r Yes, specity Cubal I∐Yes 2 <b>∑</b> No	Specify:	nican, etc.)		Whit		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Midcal Eventinat must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give .	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of worki		16b. Kind of Bu		dustry	
22	iled wi Hygier Ither th	S	10 17. Father's Name (First, Middle, Last)	elect	rican	18. Mother's Name	(First, Middle, N	Electr Maiden Surnam			
ano	ld be f lental l ked of	To Be	Leonard Webb			Edna Pac					
lary	2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a						
e, s	1 and Health em 27		Edward Webb  20a. Method of Disposition 20b. Pla	5955 ce of Dispo	Quinn On sition (Name of natory or other plac	chard Rd	Frederi	ck, MD 20c. Location -	2170 City or To	wn, State	
Baltimore,	: Pages tment of tant: If it iury or c		4 Donation 5 Other (Specify) Suns	et		1/24		Berlin			
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1	Physician /Medical Examiner		23a, Part 1. Inter the disease, or complications that caused the death. shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	crau	er the mode of dyin	ng, such as cardiac	or respiratory arro	est,		Approximate Interval Betw Onset and D	veen
68760,	icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen								
O. Box	ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of de the pr	death 3	☐ Ectopic pregnanc	у			te of deliv		/ear
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/ital	Physician; Thr this certificate ral director, pag	Be C	25. Was case referred to medical examiner?		1046	26. Place of Dea	th (Check only or	ne)		II	4.00
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Division	or Attending after death. Director; After in by the fune	Certification:	Investigation       Investigatio	ne, farm, st		iles Z INO	28f. Location (S City or Tow	itreet and Numl n, State)	ber or Rur	al Route Num	nber,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical Ce	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my know 2   Medical Examiner: On the basis of examinat and manner stated.	vledge, dea ion and/or in	th occurred at the ti nvestigation, in my	ime, date and place opinion, death occu	e, and due to the or rred at the time, o	cause(s) and m date and place,	nanner as and due	stated. to the cause(s	;)
	To the within To the comple	Mec	29b. Signature and title of certifier	0	29c. Licens	se number	2	29d. Date signe	ed (Month)	, Day, Year) 2 00 9	1
	14+1		30. Name and address of person who is impleted cause of death (Item	23a) (Type,	Print)	5T.M	TAiny	21	771		
		ate rar	31. Date filed (Month, Day, Year)  JUL 2 2 2009  32. Fegistrar's Signat			- 1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 20Ŏ̈̈̈ 3:28 A <sup>™</sup> Edward Leo Wisniewski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester 109 Quillen Dr. Berlin 8. Date of Birth Month, Pay, Ye. 2/24/1920 Birthplace (State or Foreign Country) If Under 1 Year ] If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F 89 MD 215-01-3232 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event, the Madical Evantment or other traumatic event or other event or other traumatic event or other traumatic event or other 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director MD Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21811 USA 109 Quillen Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white Specify: ģ 3 Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thief Wisniewski Judith Rutkoustra ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 109 Quillen Dr., Berlin, MD 2181 Alice L. Wisniewski / wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/23/2009 Frankford, DE Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEON ATTUAN Immediate Cause (Final BUSEAS **Physician** nescle disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** PENTENSIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🖎 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1∐Yes 2K∏No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident after death the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely f (Check only one)

BA 15 +1

State Registrar 31. Date filed (Month, Day, Year) JUL 2 2 2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

29b. Signature and title of pertifie

10324 OLD OCEANCITY BWD. BEKLIN, MD 21811 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July  $A^{\,\mathsf{M}}$ Elisabeth Roennau Young 2009 2:10 16 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ginger Cove Health Center Anne Arundel Annapolis 9. Birthplace (State or Foreign Country)

Towa If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 M 2 Months Days Hours Min. July 9, 1915 94 Director 507-10-6731 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Predict Examiner must be rediffied at once. 1 XYes 2 □ No Maryland Anne Arundel **Annapolis** Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1200 West Street 21401 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2X∑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2XXNo Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White þ ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Management Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry G. Roennau Emma Golka ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Young/daughter 1200 West Street Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 7/18/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** Failure to thrive, adult one month disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** End stage advanced dementia five vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of/ Examine Hospital or Attending Physician: The law requires that the death certificate be executed burlal-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🕱 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Congestive heart failure 1 ☐ Yes 2X13 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2XNo 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 🙀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death,

To the Funeral Director: After this completely filled in by the funeral dir Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X atural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D0029571 July 17, 2009 30. Name and address of person who completed cause of death frem 23a) (Type, Print) Paul Berez, MD

29

State Registrar 31. Date filed (Month, Day, Year) JUL 21

2225-E Defense Highway Crofton, MD 09-05987 Kaye Dee Barrov

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ye Dee Barro		State of Maryland / Department of Certificate of Ce	
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death  Month Day Year 1212 brs
edical Exami	ner	Kaye Dee Barrows  4a. Facility Name (if not institution, give street and number)	July 31, 2009 12 12 11 S  4b. City, Town, or Location of Death 4c. County of Death
		Doctors Community Hospital	Lanham Prince George's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		$212-21-8071$ $_{1 \text{ M}}$ $_{2} \text{ X}_{\text{F}}$ $_{21}$ $_{Y}$	/rs. Months Days Hours Min. Apr 19, 1988 Country)MD
<b>A</b> 2		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	tration 10d. Inside City Limits
low an		MD Prince George's Bowie	1 X Yes 2 No
Maryland 28a-f show any d at once.	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
the M a or 2		12324 Manship Lane	20715 USA
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho- traumatic event, the Medical Examiner must be notified at once.	Funeral		Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
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ours aft ttural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	lent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
6 172 ho an "ng cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use retired)
003 withir giene. her th	omp	17. Father's Name (First, Middle, Last)	ent Education  18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 within 7 Mental Hygiene. marked other than cevent, the Medical	Be C	Bart Lee Barrows	Laura Lee Lighter
212 ould b d Men s marl	ToE		ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD nd 2 sh alth an m 27 i			24 Manship Lane Bowie, MD 20715 position (Name of cemetery, Date 20c. Location - City or Town, State
Ore, es lar of Hea If ite		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		4 Donation 5 Other Specify.	burney Crematory 08/03/09 Woodbine, MD
Ba Depa Imp	, 13	Bone & Little MO1251 B	Severly L. Heckrotte, P.A. Clarksville, MD 21025 or the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line.	Between Onset and
/Medical vaminer		Immediate Cause (Final disease a Narcotic (heroin) in	ntoxication Death
		b.	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse	
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. Box 68760, he death certificate be the death certificate by the attending physic hed for use as the burned to the contract of the contract o		past 12 months?	Fetal death 3 Ectopic pregnancy Month Day Year
OX 6 eath ce attend for use	Physician/N		Other (Specify)
- o - o		Part II. Other significant conditions contributing to death but not resulting in th	ne underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by tuneral director, page 2 should be detach.	d by		1 Yes 2 No 3 Probably 4 Unknown
ords w requisite pen	Completed		24a. Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of
Reco	mo;		performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No
tal F certifi ector,	Be	25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Outpatient	26.Place of Death (Check only one)  ent 3 DOA Other4 Nursing Home 5 Residence 6 Other:
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Division of Vital Records, state derivation of Vital Records, sale or Attending Physician: The law requiral breeders. After this certificate has been seled in by the funeral director, page 2 should the control of the	ifica	2 Accident Investigation 3 Suicide 6 X Could not be	
Di spital nours a neral I	Certification:	4 Homicide determined (Specify) house	Bowie, MD
Division  To the Hospital or Attendia within 24 hours after death. To the Finneral Director: A completely filled in by the for	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death ocone) Medical Examiner: On the basis of examination and/or investi	ccurred at the time, date and place, and due to the cause(s) and manner as stated.  igation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To t	Med	and manner stated.  29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
		Ususia Melkars	O.C.M.E. August 1, 2009
50 kmd		30. Name and address of person who completed cause of death (Item 23a)	- Land Date - MD 61001
			Penn Street, Baltimore, MD 21201
S Regis	tate trar	31. Date filed (Many, Pay Year) 2009 32. Jegistrar's Signatur	all

#### Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O Day Year 03:3350 Bernard Warren Baker 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death RAL MORE GOOD SAMARITAN HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 XM 2 □ F 218-26-5139 79 May 4,1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Baltimore Parkville 1 ☐ Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7816 Highpoint Road 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Mill Master Electrician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Bernard Baker Margaret E. Abrams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Baker-son 15603 Home Road-Sparks-Glencoe, MD 21152 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Aug. 10, 2009 Parkville, Maryland 22. Name and Address of Facility Evans Funeral Chapel 21. Signature of Funeral Service Licensee 8800 Harford Road Parkville,MD 21234 ondrae And Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) Due to (or as a consequence of) NEUMO NIT Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Division of Vital Records, P.O. Box 68760, attending physician for use as the burial this certificate has been sial director, page 2 should After after death.

I Director: Af of in by the fur within 24 hours after

To the Funeral Dire

completely filled in b

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other tha any Injury or other traumatic event, I'm. I once.

**Physician** 

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Funeral

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death with the Marylar

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the

State Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

RES OO

29d. Datę signed (Month, Day, Year)

12009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANDALEEB ABRAR AHMED SECTION ROLL BIVEY RATE MORE IND 21229. Baltimore, mo 21239

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

06 2009

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 12:35 PM lock acoly 2005 IA YR 351 /Medical 4a. Facility Name (If por Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Road leasant Valley Raltimore Date of Birth (Month, Day, Year) 9/12/1929 Age (In yrs. last birthday, Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🖾 F 218-26-1458 79 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examiner must be notified at 1 ☐Yes 2 X No Director Catonsville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21228 1413 Pleasant Valley Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important; If Item 27 is marked other the any Injury or other two contracts. Her Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Knight Edward Arnold 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3918 Falls Rd., Randallstown, MD 21133 Eric Block/Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Sonation 5 ☐ Other (Specify) Lake View Mem. Park 8/8/09 Sykesville, MD 21. Sig att re of Funeral Service Lig 22Burrie Adultu Greenity Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Onset and Death complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art1. Inter the disease, or complication shock, or heart failure. List only one of 23a art 1. Immediate Couse (Final disease or condition result not in eath) **Physician** 10005 CODOLL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of). P.O. Box 68760. attending physician Physician/Medical the use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) □Yes 2 No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ spertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 X No certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death.

E Funeral Director: After letely filled in by the funeral Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the control of the con 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

DURST

AUG 0 6 2009

GEORGE

31. Date filed (Month, Day, Year)

Zoos

Maryland

(Etonsville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#5perFH, 6895, 9/8/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2 2009 9:30 A AUGUST BACKOF CONNIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Num 6308 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 2 F 5/7/1952 KY 57 407-76-Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Frederick Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21771 14909 Chelsea Circle Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Dr. McCorkle 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Christine Johnson ပ Dean Elroy Adams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14909 Chelsea Circle, Mt. Airy, MD 21771 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. Gary Backof/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 8/7/09 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Libertytown, MD Peter the Apostle Cem. 4 □ Donation 5 □ Other (Specify) \$t. 21. Signature Funeral Service Live <sup>22</sup>Burrater Gueenty Funeral Home & Crematory, P.A. ÛU 1212 W. Old Liberty Rd., Winfield, MD 21784 Approximate Interval Between Onset and Death 23a. P. rt1. En er the disease, or complications that caused the hock, o heart failure. List only one cause on each line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Imm vdiate v use (Final TRACRANIAL HEMMURUAGE **Physician** N diseas condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cur to for as a consequence off Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₽No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death within 24 hours after death

To the Funeral Director;
completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0063498 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAKUVINDER WAPHWA 400 w 7th St. Frederick, HD 21701 32. Registrar's Signature 31, Date filed State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	_	Department of Health and N Certificate of Death		iene <sub>eg. No.</sub> 2009	25084
	Physici /Medi		1. Degedent's Name (Firşt, Middle, La:	BROWDER		2. Date of Death	Day Year 2009	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	and the second s	4b. City, Town, or Location of Death BALTIMERE C.TY		4c. County of Deat	n
Ī	Funeral Director		5. Social Security Number 7 6. S 219-38-1814 -	ex 7. Age (In yrs. last bir	thday) If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth	Year 42 9. Birt	nplace (State or Foreign
دو د	Maryland a-f show	jo	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside Øity Limits 1 ☐ Yes 2 ☐ No
BROWDER	with the Na or 28a-	al Director	10e, Street and Number	t AVE.	10f. Zip Code 2	10	og. Citizen of What Co	untry?
S S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and the position and once.	by Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give	13. Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
NATRAN 215-0036	iin 72 hours . "natural" in dien Ex	Completed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Et (Specify only highest grade)  Elementar Secondary (0-12)	ade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	Shift of Business/	non-stry
2 5	be filed with tal Hygiene dother tha	Be Com	17. Pather's Name (First, Middly Last	College (1-4or 5+)	H ()	(First, Middle, N	Miden Surname	ENTER
\νανν \ Maryland	12 should the hand Meni 7 is marked traumatice	ဥ	19a hformant's Name/Relationship (	Type Print   19b	Mailing Address (Street and Number/or FIS	ral Route Nuprie	City or Town, State	tip Code)
- 0	ages 1 and int of Healt it: If item 27		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	Disposition (Name of y, crematory or other place)	Date Jawk	7 CO - 1 City of 20c Location - City of 20c ANGSOLO	Town, State MC
PATIENT   Baltimore,	permit. P Departme Importan any Injury		4 □ Donation 5 □ Other (Specification of Fundral Service Licer		22. Name and Address of Facility	SEPH GI	AUG H	7.16ME
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a consequence				1 day
1.08	xecuted and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	of):			
8760, \$	ate be e nysician he buria		resulting in death) Last	Due to (or as a consequence of	of):			
O. Box 6	ifi S	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
rds, P.	quires that an signed b uld be deta		Part II. Other significant conditions of	contributing to death but not resulting in	1		pacco use contribute to	the cause of death?
Division of Vital Records,	sician: The law rescrificate has bevirector, page 2 sho	Completed by	diabetes mellitus to serzure disorder	9pe 2		24a. Was at autops perform	v prior to	topsy findings available completion of cause of
Vita	yslclan: is certific director,	To Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Ou	Other:	th (Check only on	e) ence 6 ☐ Other (Spe	cify)
ion of	nding Ph ath. r: After th		27. Manner of Death 1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of injury (Month, Day, Year)	Time of njury at Work?  M 1 □ Yes 2 □ No		w injury occurred	
Divis	ital or Atters after devaled in Directo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		rm, street, factory, office	28f. Location (St City or Town	reet and Number or Ro n, State)	ural Route Number,
	he Hospi in 24 hou he Funer pletely fill	Medical			e, death occurred at the time, date and place ad/or investigation, in my opinion, death occu			
	To t To t	Σ	29b. Signature and title of certifier	M.	29c. License number	2	9d. Date signed (Mont	1, Day, Year)
	2	1		completed cause of death (Item 23a)	(Type, Print)			/
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	of HOSPITAL of BALL	TIMBRE		
	Registi	ar	AUG 0 6 2009	Clever D. Da	West .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 Year Physician Herman A. Bachmann August 2 12:17 p <sup>M</sup> /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Harwood Mandrin House 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1**IX**M 2□ F Months Days April Maryland 1931 78 215-28-0078 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant; If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10h County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Experiment natities to notified at 1 ☐ Yes 2 🛣 No Anne Arundel West River Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 20778 4504 Owens Valley Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 mo If Yes, Give Year or Dates:1952-55 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Route Salesman Schmidt Bakery 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Schmedes Bachmann Frank ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4504 Owens Valley Drive West River Md. 20778 Elizabeth Bachmann/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Md. 8/4/09 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Hwy. Balto. Md. 21225 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1) Secre **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Hlnknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? has 2 **2** No 2 No certificate 1 ☐ Yes 1 TYes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 557 CA Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To HOUSE funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After Hospital or Attending Injury 5 Pending investigation 17 Natura 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 3,2009

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed Month, Day,

34 owensville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

my Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Janet W. Connor 2009 11:45 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville Brightwood Center If Under 1 Year | If Under 24 Hrs. | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 ☐ XF Balt., Maryland 217-24-0535 81 3/2/1928 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No r 28a-f sh notified Maryland Baltimore Towson Director 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number must be n 21286 1019 Roxleigh Road America Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married white 1 ☐ Yes 2 ☒ No Specify: Baltimore, Maryland 21215-0036 à 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City other than vent, the Me Elementary/Secondary (0-12) College (1-4or 5+) Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet Krantz Joseph White 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1019 Roxleigh Road Towson, Maryland 21286 Mr. Charles Connor, Sr. / spouse 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Evans Funeral
Chapel- Bel Air August 6, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leaceful Alternatives Funeral & Cremation Ctr., P.A. Leaceful Alternatives Funeral & Maryland 21093 2325 York Road Timonium, Maryland 21093 23a. Part/ Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or likear failure. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Breust Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed use as the burial-trar Due to (or as a consequence of). Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached a linknown O law requires that the 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division or Vital Records, 1 | Yes 2 | No 3 | Probably 4 | Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 ☐ No this certificate 2. No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3□ DOA 1 ☐ Yes 1 Inpatient ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral Certification: After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö within 24 hours a 1 Certifying Physionan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exampher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifler 30. Name am address of person who completed cause of death (Item 23a) (Type, Print) 0 JUNEWAT, J 202 SVNE VESSO 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4, 2009 Year August 5:30 PM Colhouer Timothy Michael 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Glen Burnie 1327 Aster Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Months Days Hours 1 ፟M 2 □ F 219-64-9384 54 April 12,1955 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1327 Aster Drive 21061 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White If Yes. Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Correctional Officer State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Colhouer Sarah Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Dennis Colhouer/Brother 8312 Birchmere Terrace Ellicott City, MD 21043 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 6, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signalar of Funeral Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 101 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final I)a disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

and

attending physician

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

ò

Completed

Be

**Funeral** 

Director

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be reclined at

Examiner burial-transit Physician/Medical for use as the After this certificate has been signed by the funeral director, page 2 should be detached 2 Completed Be spitat or Attending Pl hours after death. neral Director: After t y filled in by the funera

Certification: To

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

24a. Was an 2 **7**No 1 ∐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 □Yes 2 🗆 No

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hospital

5 Pending investigation

6 Could not be

1 Inpatient

and manner stated.

29d. Date signed (Month, Day, Year)

PASADENA MD 21122

30. Name and address of person who completed cause of death (Item 23a) (Type TCHIR IMY

31. Date filed (Month, Day,

29b. Signature and title of certifier

32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral D Hospital

10 V

completely

2 ER/Outpatient 3 DOA

Physici /Medi Exami

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit
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	For State		State of M	aryland		artment of H r <i>tificate of L</i>		ana ivie			0000	00	000
	Registrar  1 Decedent's Nam	ie (First, Middle, Las	at)		Cei	tilicate of t	Jeani		R. 2. Date of Deat	eg. No.	2003	3. Time o	of Death
an		liam				C-1:00			Month August	Day	2009		) p M
al er			John e street and number)			Cohill 4b. City, Town, or	Location of	f Death	nuguse		County of Dea		, 12
e.		Kavanagh				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dunda					timore	
	5. Social Security N	lumber 6. S	ex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	8. Date of Birth (Month, Day,	Voor	9. Bi	rthplace (State ountry)	or Foreign
	217-24-	3126	<b>€</b> M 2□ F	81	Yrs.	Months Days	Hours	Min.	January	9,	1928	Marylo	ınd
	Usual Residence of	f Decedent 10b. County		10c. City, T	Farring and a							10d. Inside C	Pity Limite
5	Md.	_	imore	Toc. City, 1	IOWII OI LO		01.						S 20 No
ect	10e. Street and Nu			<u> </u>		Dunda 10f. Zip Code	en		14	Og Citi-	zen of What C		
흐			2 1			·	24 2 2 2		'	og. Oili			
Funeral Director	11. Marital Status	Kavanagh	12. Was Decedent	Ever in IIS	13 \		21222		afv Yes or No-	1.	<i>USA</i> 14. Race - Am		
F		ied 2 Married	Armed Forces? 1 □ Yes 2 □			Was Decedent of H f Yes, specify Cuba	n, Mexican,	, Puerto R	ican, etc.)		Black, Whi		
	3 🗆 Widowed	0	If Yes, Give Year or Dates:			1 □Yes 2 □ytNo	Specify:				Specify: W	hite	
Completed by	(Spec	15. Decedent's Ed	lucation	1		dent's Usual Occup kind of work done o		of working	,	16b. Kir	nd of Business	/Industry	
du	Elementary/Seco		College (1-4or !	5+)	life.	OO NOT use retired	)	or working	9			_	
ខ្ល	12 yea			i_		Орега					Ste	el	
Be		(First, Middle, Last)						,	(First, Middle, I		Surname)		
ပ္		iam J. Col		T					Holola		T 01.1	7: 0 / )	
		ame/Relationship (	,			ng Address (Street a							
	20a. Method of Dis	eth Cohile	e wa	<b>fe</b> 20b. Plac	e of Dispo	8 Kavanag sition (Name of		Da	ite		21222 cation - City o		
		☐ Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State			natory or other place n Cemeter		Au gu 2 200		Du	ındalk,	Maryla	ınd
	21. Signature of Fu	preral Service Licen	Specific Control of the Control of t		22	2. Name and Address Connelly 7110 Soll	ss of Facility Funer	al Ho	ome Of	Duna	lalk, P	.A.	22
	23a. Pa 1. Ever t	the disease, or comp	plication that cause	the death.	Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory arr	est,	ack, P	Approxima	ite
	Immediate Cause	(Final	one cause on each li	ne. Cciv						^		Interval Be Onset and	Death
	disease or condition resulting in death)		a. Due to (or a									lamos	<u>&gt; *                                     </u>
	Cognoptically list on	n ditions	h										_
iner	Sequentially list co if any, leading to im cause. Enter Under Cause (Disease or	nmediate	Due to (or as	a consequen	nce of):								
Gam	Cause (Disease or that initiated events resulting in death)	5	C										
edical Examiner	i odanija i odanija		Due to (or as	a consequen	ice or):								
dic			d										
Me.	IF FEMALE:	t nromont	23c. If yes, outcome	of pregnanc	у					Π,	23d. Date of d	elivery	
Completed by Physician/M	23b. Was deceden in the past 12 1 ☐ Yes 2 [	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ctopic pregnancy Other (specify)	/			1	Month	Day	Year
hysi	9 ☐ Unknown		9 ☐ Unknown										
γP	Part II. Other signi		ontributing to death b		•		-			bacco u	se contribute	to the cause of	death?
edk	Hyperter	nsive At	horosilei	OHC C	will	ovusus	ur 1)	rseus	£ 1□Ye	es 2[	□ No 3 □ F	Probably 4 🖵	Onknown
plet									24a. Was a		24b. Were a	utopsy findings	available
ē									autops perform		death?		cause of
Be	25. Was case refer examiner?	rred to medical					26. Place	of Death	(Check only on				
ပ္	1 ☐ Yes 2 ☑		Hospital: 1 ☐ Inpati	ent 2 EF	3/Outpatier		4 LI Nui	rsing Hom	e 5 Reside	ence 6	6 □Other (Sp	ecify)	
on:	27. Manner of Deat 1 Natural	5 Pending	28a. Date of Inju (Month, Da	ury 28 ly, Year)	Bb. Time of Injury	Work			8d. Describe ho	ow injury	y occurred		
cati	2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be					Yes 2□N		06 lti (O			3 - 1 D 1- No.	
ertif	4 Homicide	determined	building, el	c. (Specify)	s, lailli, Sir	eet, factory, office		20	8f. Location (Si City or Town			turar noute ivui	nber,
S S	29a. Certifier	1 Certifying Ph	ysician: To the best	of my knowle	edge, deat	h occurred at the tir	ne, date an	d place, a	nd due to the o	cause(s)	and manner	as stated.	
Medical Certification: To	(Check only one)		niner: On the basis of and manner st	of examination									(s)
ž	29b. Signature and	title of certifier				29c. Licens			-			nth, Day, Year)	
	► Key	ruther	CIVII			Discil	ولون		1	My	USF 5	,2009	
	0.	0	completed cause of				Rais	11		mi	1 7:5	16	
to	31. Date filed (Mon	nth, Day, Year)		rar's Signatur		nt ld.	viu (	TIME	she "	w(1	) (1)	~17	
te ar	AUG	0 6 2009	Beneva	1. 4	ares								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Year 10:25 August Eva R. Chornyei 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Tate Hospice House Linthicum 8. Date of Birth (Month, Day, Year) aug.4 1928 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 1 ☐ M 2 🖫 F 80 Georgia 413-36-1660 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Halethorpe Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 21227 2637 Tulip Ave. 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □Yes 2 No Specify: White Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proctor and Gamble Technician 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leahava Simmons Sam Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2637 Tulip Ave. Baltimore Md. 21227 Frank Chornyei/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, Md. Glen Haven Cemetery 8/5/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Gonce Funeral Service P.A. 4001 Ritchie Hwy. Balto. Md. 21225 6. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gastrointestinal Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) diac Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes 2 No 26. Place of Death (Check only on ) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical **Examiner** 

**Physician** 

Examine

**Funeral** 

Director

28a-f show

Director

Funera

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Completed

Be

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Md.

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nuffled at

Maryland 21215-0036

altimore.

/Medical

burial-transit and attending physician as the t for use signed by the a cate has been si page 2 should b certificate

Examine Physician/Medical \$ Completed ours after death.

neral Director: After this certificatilled in by the funeral director, process. Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 2 No 1 Tes

4 Thomicide

(Check only one)

29a. Certifier

Medical

27. Manner of Peath Natural 5 Pending investigation 2/ Accident 3 Suicide

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐Yes 2 ☐No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D39505

29d. Date signed (Month, Day, Year)

State

Registrar

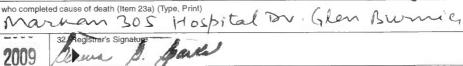
24 hours a

within 2.

10

31. Date filed (Mouth Day, Year) 06 2009

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09-05800 Shorto Ellio		Please Type or Print i						
Shonte Ellis	1	State of Maryla - For State		nent of Health a cate of Death	ina ivientai r		20	09 2509
Physicia		egistrar  I. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
Medical Examir		Shonte	e' Sheron	Ellis <del>- Ellis</del>		July 25, 200	Day Year D9	0248 hrs
		a. Facility Name (if not institution, give street and n			or Location of Dea	th	4c. County of Deati	n
	4	Johns Hopkins Bayview Medical Cen		Baltimore		In Date of Birth	AN USBACOOK B	rthplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 215-04-6147 6. Sex	7. Age (In yrs. last bi	Months D	ear If Under 24H ays Hours M	_		puntry) MD
Sirector	-	Jsual Residence of Decedent	21	Yrs.		J-31	1302	
any	-	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
and show	٦	MD N/A	Balt	imore				1 X XYes 2 No
Maryls 28a-f	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou US	
h the 33a or		4820 Midline Road		212				
th wit	Funeral	11. Marital Status  1 X Never Married 2 Married Armed F	cedent Ever in U.S. forces? No	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? ( pan, Mexican, Puer		14. Race - Ame White, etc.	rican Indian, Black,
ter des		3 Widowed 4 Divorced If Yes, Give Ye		1 Yes 2 X	No specify:		Specify:	Black
urs af ntural	d b	or Dates: 15. Decedent's Education (Specify only highest gra		. Decedent's Usual Occu	pation (Give kind o	f work done	16b. Kind of Business	/Industry
6 172 hc	Completed by		1-4 or 5+)	during most of working  Nurse	iire. DO NOT use n	etirea)	Genesia	s N/H
003 within giene.	E .	12th grade 1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	rear	Nulse	19 Mother's Na	ne (First, Middle, M		
15- Filed al Hyg ced oth	Be C	Charles Ellis				a McMil		
212 ould be Ment mark	리	19a. Informant's Name/Relationship (Type, Print )	1	9b. Mailing Address (S	treet and Number o	r Rural Route Num	ber, City or Town, Stat	e, Zip Code)
MD 21215-0036 nd 2 should be filed within 7 sith and Mental Hygiene. m 27 is marked other than		Linda McMillion-Mot					MD 21206	
ore tra		20a. Method of Disposition  1 X X Bunal 2 Cremation 3 Removal		e of Disposition (Name of atory or other place) Memorial		Date -1-2009	20c. Location - City o	lstown, MD
Page Page ment c		4 Donation 5 Other Specify:	KING					1500
Baltimore, MD 21215-0036  permit Pages I and 2 should be filed within 72 hours after death with the Maryland bearment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show any injury or other tranmatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		22. Name and Addr		arcn ња Avenue		MD 21202
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that						Approximate Interval
/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple G	unshot Wounds					Between Onset and Death
' caminer			a consequence of):	<del></del> ·				
	7.	Sequentially list conditions, if any, leading to immediate b. Due to (or as	a consequence of):	<del></del>				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	a consequence on.					
ed	Exal	events resulting in death) Last Due to (or as	a consequence of):					
executed ian and ial - transit	ical	d. X AMENDED	T + # 1 W	IE,G894,8/6/	00 UC			
Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physicipage 2 should be detached for use as the buri	Med	IF FEMALE: 23c. If yes	, outcome of pregnand	1E,G094,0/0/	09,WS		23d. Date of delive	ery
Box 68760, e death certificate be the attending physic ed for use as the bur	sician/Med	past 12 months?	birth gnant at time of death	2 Fetal death	3 Ectopic pre	gnancy	Month	Day Year
30x Jeath of e atter	ysic	1 Van 2 No Cal Hakaawa	nown	5 Other (Specify)				
O. E at the at the tached	, Phy	Part II. Other significant conditions contributing	to death but not result	ting in the underlying cau	se given in Part I.		bacco use contribute	
F. P.O.	d by					1 Yes	2 V No 3 Pr	
ords  » requ s been shoult	Completed					24a. Was autop	sy prior to	autopsy findings available completion of cause of
Recol The law cate has	E					perfor 1 <b>✓</b> Yes	rmed? death? 2 No 1 ✓	
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical examiner?		26.P	Place of Death (Che			
F Vit Physic rr this	2	1 ✓ Yes 2 No		Outpatient 3 DOA b. Time of Injury 28c.	Other: Nu Injury at Work?		Residence 6 Oth	ner:
Division of Vital Records, to Attending Physician: The law requirers after death.  The Director After this certificate has been simplified in by the funeral director, page 2 should be	jon:	27. Manner of Death  1 Natural 5 Pending  28a. Da	th Day Year)	210 hrs 1	Yes 2 ✔ No	Subject sho	t	
ivisior or Attend after death Director:	icat	2 Accident Investigation 28e. Pla	ace of Injury - At home	, farm, street, factory, offi	ice building, etc.			Rural Route Number, City
Divis pital or At ours after d eral Direct	Certification:	3 Suicide 6 Could not be determined (Specification)	Parking Lot			or Town, S 4217 Erdman	state) Avenue, Baltimore	, MD
		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge,	death occurred at the tim	e, date and place,	and due to the caus	e(s) and manner as st	tated.
To the Hos within 24 h To the Fut completely	Medical	one) 2 Medical Examiner:On the basi and manner	s of examination and/c stated.			ed at the time, date		
	Σ	29b. Signature and title of certifier	1 / 1		.C.M.E.		29d. Date signed (A July 25, 2009	nonus, Day, rear)
		30. Name and address of person who completed ca	Use of death (Item 23:				1, 20, 2000	
(6)		Carol Allan, MD Assistant Medica		1 Penn Street, Bal	timore, MD 21	201		
	ate	31. Date filed (Month Oat Y2009 32.	Registrar's Signature	barker		· -··· · ·		
Regis	trar	AUG 0 0 2000 /00	7.7		_			

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

09-06060 Douglas Houglund Ме

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

gias Hougiui		State of Mar 1- For State Registrar	ryland / Departmei <i>Certificat</i>	nt of Heal te of Deat			eg. No. 20	09 2509
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Dea	ith	3. Time of Death 1800 hrs
dical Exami	ner	Douglas Houglund  4a. Facility Name (if not institution, give street an	nd number)	4b. City. T	Town, or Location of	Month August 3,	4c. County of Dea	
		Route 4 South and Upper Pindell I		Lothia			Anne Arunde	el .
Funeral Director		Social Security Number     6. Sex	7. Age (In yrs. last birthd	day) If Under		Min.	rth(MM/DD/YYYY) 9. E Fore	eign Canada 📗
Director		526-31-4756   1 X M 2   Usual Residence of Decedent	F 67	Yrs.		July 1	.8, 1942 C	Country)
any		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
fand f show	ē	Arizona Maricopa	Sc	cottsdal				1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		10f. Zip			10g. Citizen of What Co	untry?
with the is 23a contil		2629 North 73rd Place		13. Was Decede	85257 ent of Hispanic Orig	gin? ( Specify Yes or No	Canada o- 14. Race - Am	erican Indian, Black,
or item	Funeral	1 Y				, Puerto Rican, etc.)	White, etc.	
rs after nral", miner	ρ	Widowed 4 XDivorced If Yes, Given or Dates:  15. Decedent's Education (Specify only highest			X No specify:	kind of work done	Specify: Wh:	
72 hou n "nat	Completed				rking life. DO NOT			J
within jene.	duc	4	+ Mair	ntenance	Enginee			Maintenance
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Be	17. Father's Name (First, Middle, Last)  Charles A. Houglund				's Name (First, Middle, Joyce Hart		
212 nould b id Meni is mark	T P	19a. Informant's Name/Relationship (Type, Print	·		(Street and Nun	nber or Rural Route Nu	mber, City or Town, Sta	
and 2 shou tealth and N tem 27 is n tranmatic		Kevin D. Houglund, Sc 20a Method of Disposition		373 Covi		Rancho Cu	camonga, C	
ages 1 and of H		1 Bunal 2 X Cremation 3 Remov	val from State cremator	y or other place	)			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Tho	mas Gregor	remator	Address of Facilit	08/05/09	lend Tro	e, Maryland
		Tumas Du-	-	299 Fr	ederick	Road Balti	yland, Inc more, Mary	land 21228
Physician /Medical		23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.		enter the mode	of dying, such as c	ardiac or respiratory ar	rest, shock, or heart	Approximate Interval Between Onset and Death
caminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple  Due to (or	as a consequence of):					- Bodin
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or	as a consequence of):					
	Examiner	cause. Enter Underlying Cause						
xecuted n and - transit		events resulting in death) Last Due to (or d.	as a consequence of):					
oe exec	Medical	UNPENDED AMEND	ED					
lox 68760, leath certificate be ex- e attending physician for use as the burial -	J/Me	22h Was decedent programmt in the	yes, outcome of pregnancy	Fetal death	3 Ectopi	c pregnancy	23d. Date of deliv	ery Day Year
Box 687  e death certific  the attending p  ed for use as th	sician/I	past 12 months?	Pregnant at time of death 5	Other (Spe	-	o programoy	, month	54,
ш è ± b	Phys	Part II. Other significant conditions contributi	Inknown ing to death but not resulting i	in the underlying	cause given in Pa	art I. 23e. Did	tobacco use contribute	to the cause of death?
Division of Vital Records, P.O. B tall or Attending Physician: The law requires that the d rs after death.  "In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached	þ						es 2 <b>V</b> No 3 P	robably 4 Unknown
v requires peen should	ompleted					24a. Was		autopsy findings available to completion of cause of
tal Records ian: The law requ certificate has been ector, page 2 should	,om					perf 1 <b>V</b> Yes	ormed? death 2 No 1	
Vital Pysician: ysician: his certifi director,	Be C	25. Was case referred to medical examiner?	Inpatient 2 ER/Out		26.Place of Death	(Check only one)  Nursing Home 5	Desidence 6 20	haw Sanaa
n of Vi ling Physi After this funeral dir	임	1 ✓ Yes 2 No 22. Manner of Death 28a. I	Date of Injury 28b. Til		28c. Injury at Worl		Residence 6 🗸 Ot	ter. Scene
ion tendin eath. for: A	ation	1 Natural 5 Pending Investigation	Month Day Year) 3, 2009 1756 I	hrs	1 Yes 2 🗸	No Passenger	auto fixed object	collision
Division pipe of the control of the	ertification:	3 Suicide 6 Could not be 28e.	Place of Injury - At home, farm		, office building, e	or Town.	State)	Rural Route Number, City
E 8 E E	ပ	29a. Certifier	ecify) Major Road / Hig e best of my knowledge, death		e time, date and n		th and Upper Pindel	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	one) 2 Medical Examiner:On the ba					• •	
F 3 F 5	ğ	29b. Signature and title of certifier		29	c. License number		29d. Date signed (/	
			two		O.C.M.E.		August 4, 2009	,
5V		30. Name and address of person who completed Donna M. Vincenti, MD Assista	nt Medical Examiner	111 Penn	Street, Baltim	ore, MD 21201		
	ate		2. Fegistrar's Signature		6			
Regist		AUG V 6 2009 L	Clause of	GINAL	,			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 06:55PM 2009 August Umeko Mary Harker 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Timonium

If Under 24 Hrs. Baltimore Stella Maris Hospice Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, You NOV • 25 Social Security Number 7. Age (In yrs. last birthday, Year) Days Hours 1 ☐ M 2 🛛 F Nov. 1930 78 Yrs. Japan 220-66-0535 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2X No Maryland Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21014 423 Rose Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Asian 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker R 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tan Nishijima Yokichi Matsuyama 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 423 Rose Way, Bel Air, Maryland 21014 Theresa Otwell (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Middel River, Maryland 8/6/2009 Holly Hill Memorial Grnds 4 Donation 5 Dother (Specify) 21. Signature of funeral Service Licensee 22 Name and Address of College & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. The indisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or han failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumonia Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

P.O. Box 68760, Records, HARKER, Division of Vital Hospital or Attending Physician;

Physician /Medical **Examiner** ending physician and use as the burial-tran (or: After this certificate has been signed by the the funeral director, page 2 should be detached within 24 hours after death

To the Funeral Director:
completely filled in by the

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Certification: To

Medical

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Exon her must be notified at once.

Baltimore, Maryland 21215-0036

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 □Yes 2 □ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  $\frac{NURSE}{NURSE}$ (Check only one) 29c. License number R 1502 S 9 29d. Date signed (Month, Day, Year) d title of certifier 29b. Signature

2300 DULANEY VALLY ROAD TIMONIUM MD 21093

3

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrade Signature

CRNP

MARIAM BAKIR ate filed (Month, Day, Year) AUG 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9.15 AM Krop Toanne 2009 Jary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Overlea Health & Rehab Center Baltimore 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Nov 4, If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Min. Hours Months Days 1 □ M 2 💢 F 1919 89 219-01-4451 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director Perry Hall MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21128 **USA** 5113 Robins Pearch Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unk) Bertha Frank Brzostek ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5113 Robins Pearch Lane Perry Hall, MD 21128 Kathleen Kropp/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 08/6/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus Funeral Service License Going Home Cremation Service P.O. Box 784 MO1251Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final texe then resulting in death) Gue front Due to () as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 021 Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 2 D**X**No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2**X**No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Lath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only

Examiner and as the burial-trai P.O. Box 68760 signed by the attending physician I be detached for use as the buria Attending Physician: The law requires that the death certificate be Division of Vital Records, icate has been si, , page 2 should b certificate funeral director, this After t To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu death.

**Physician** 

/Medical

**Funeral** 

Director

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nd Mental Hygiene. marked other than

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**Physician** /Medical

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

00 31. Date filed (Month, Day, Year,

certifie

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29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Redistrar's Signature

and manner stated.

backer

State

Registrar

29c. License number

09-05993 Leonard Kahl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 25094

		l- For State Registrar		Certific	cate of I	Death			R	eg. No.		
Physicia		Decedent's Name (First, Midd	le,Last)					2.	Date of Dea Month		Year	3. Time of Death
Medical Examin		Leonard E	Edward Kal	hl					July 31, 2	.009	Todi	1900 hrs
		4a. Facility Name (if not institution		ber)	4b	. City, Town, or L	ocation of	f Death		4c. Cou	nty of Deatl	
		1303 Meridene Street				Baltimore						
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last b	irthday)	If Under 1 Year Months Days	If Under	Min.			1Foreig	thplace (State or
Director	1	212-28-4024	1X M 2 F		78 Yrs.	MOTHERS Days	Hours	1 1	10/0	6/193	0 Co	Maryland
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v any		10a. State 10b. County		10c. City, Tow								10d. Inside City Limits  1 X Yes 2 No
laryland 3a-f show at once.	5	MD		Bal	timor	·e						
Maryl 28a-	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of		ntry?
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r deat	튑		1X Yes	2 No							Ta7 b	iite
s after	2		/orced If Yes, Give Year or Dates:	completed) 16		Yes 2 X No s Usual Occupati		rind of wor	rk done	Spec		
hour fnatu	<b>8</b>	15. Decedent's Education (Spe Elementary/Secondary (0-12)				st of working life.						Chevrolet
36 in 72 than dical	Completed	12	College (1 4	10101)	Par	ts Mana	ıger				_	
1 with	탉	17. Father's Name (First, Middle	, Last)			1	8. Mother's	s Name (F	irst, Middle,	Maiden Surna	ame)	
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		19a. Informant's Name/Relations	ship (Type, Print )	- 7		Address (Street						
MD d 2 sho lith and n 27 is		Kim Albrech	t/ Daught	er	1702	Wyclif	fe A	Aven	ue, F			MD 21234
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	ſ	20a. Method of Disposition  1 X Burial 2 Cremation	2 Domewel from	crem	natory or othe	ion (Name of cen er place)			Date			Town, State
Pages ent of roth	-1	4 Donation 5 Other S		Parl	kwood	Cemete	ery	08/0	16/09	Parl	KVIII	.e,MD
Baltimore, Moemit. Pages I and 2 Department of Health Important: If Item 2 Impury or other traumingury or other tr	1	21 Signature of Funeral Service	License	. 0	22. Na	ame and Address	of Facility	l Ch	lanel	& Cre	emati	on Services
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Physician	7	2 a Part I. Enter the disease, of failure. List only one cause		used the death. Do	not enter the	e mode of dying,	such as ca	ardiac or r	espiratory a	rest, shock, o	r heart	Approximate Interval Between Onset and
/Medical :xaminer	U	Immediate Cause (Final disease	A 41	tic Cardiovaso	cular Dise	ase						Death
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Division of Vital Records, P.O. real or Attending Physician: The law requires that the staffer death.  •I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	빏	3 Suicide 6 Cou	ald not be	of Injury - At home	e, farm, stree	t, factory, office b	uilding, et	c. 2	28f. Location or Town,		umber or R	ural Route Number, City
Spital Dours neral	Certification:	4 Homicide	ermined (Specify)					- 1			-	
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit			Physician: To the best aminer: On the basis of	of my knowledge, examination and/o	death occurr or investigati	ed at the time, da	ate and pla death oc	ace, and d curred at t	lue to the car the time, dat	use(s) and ma e and place, a	inner as sta and due to t	ted. he cause(s)
To the within To the comp	Medical	29b. Signature and title of certif	and manner sta	ated.		29c. Licens			,			onth, Day, Year)
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wx1		30. Name and address of perso Theodore M. King, Jr	(	nt Medical Exa		111 Penn Sti	reet, Ba	ltimore.	MD 2120	01		
	ate			gistrar's Signature								
Regist		AUC 0.6.20			barke							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	ertificate of Death	Reg. N	2009 25095
	Physicia	ın	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death 2009 16:30 M
	/Medic	al	Philip Lee Korman  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 31	, 2009 16:30 M
	Examin		Chapel Hill Nursing Center	Randallstown		Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 214-40-2859 67 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Dec. 18,	9. Birthplace (State or Foreign Country) Maryland
	Director		Usual Residence of Decedent		Bee. 10,	rary rand
	ryland	_	10a. State 10b. County 10c. City, Town or I			10d. Inside City Limits
	8a-f s	Directo	Maryland Baltimore Glyndon			1 □Yes 211 No
	a or 2	<u>p</u>	10e. Street and Number	10f. Zip Code		Citizen of What Country?
	ns 23	Funeral	43 Railroad Ave.  11. Marital Status 12. Was Decedent Ever in U.S. 13	21071  Was Decedent of Hispanic Origin? (Sp.		ited States  14. Race - American Indian,
0	I and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. Heath and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Medical Evaninar must be notified at	y Fur	1 Never Married 2 Married 1 Yes 2 No	<ul> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>1 □Yes 2 X No Specify:</li> </ul>	Rican, etc.)	Black, White, etc.
D-003G	hours tural",	ed by	3 ∐ Widowed 4 L Divorced Year or Dates:	edent's Usual Occupation	1 deh	White Kind of Business/Industry
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<u> </u>	2 should b and Meni Is marked raumatic e	၉	Frederick M. Korman		Peeling	
Z Z	d 2 sh th and 7 Is m traum			ling Address ( <i>Street and Number or Rui</i> <b>) Eastview Terr.</b> <i>A</i>		
ซ <sup>ิ</sup> ์	1 and Health tem 27 other tr		20a. Method of Disposition 20b. Place of Disp		Abingdon, I	Location - City or Town, State
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Dallillor	permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic ance.			22. Name and Address of Facility		isterstown Road
Ď	De m		1	Eline Funeral Home		town, Maryland 21136
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or hear trailius. List only one cause on each line.		or respiratory arrest,	Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition resulting in death)	Cancer		Onset and Death
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ָם ב	death a atter	sician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
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<b>5</b> :	s certi	Be C	25. Was case referred to medical examiner?  1 □ Yes 2 ⋈ No  Hospital: 1 □ Inpatient 2 □ EP/Outpati	Other:	th (Check only one)	6 ☐ Other (Specify)
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2 3	or Atter de lirector n by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
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	No the	Me	29b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, Day, Year)
<b>)</b>			ant	D4372	-5	8/3/09
7	21		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) Load 1	Werkn	inliter ND
	Stat	e	31. Date filed (Month, Day, Year)  32. Registrar's Signature	lye Road 1	V ZJIVV	
	Jia	ar	ALIC 0 6 2009 German D. Sark			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2089 **Physician** 11:58PM Gladys Elaine Lemons Larson August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Bel Air Brightview Assisted Living If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 M 2 F 80 Feb.14,1929 Virginia 216-30-7009 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 X No Director Baltimore Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 6 Lark Meadow Court 21236 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify: Specify: \$ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Retail permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If iten 27 is marked other tha any injury or other traumatic event, It. 1 once. Sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Lane Mintz Robert Gordon Ramey ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9425 Joppa Pond Road-Baltimore, Maryland Sylvia Lemons-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug.7,2009 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8800 Harford Road Evans Funeral Chapel and cremation services Parkville,MD 21234 endial hME toudd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 🗌 Unknown ģ Completed Be Certification: To

law requires that the death certificate be executed physician and s the burial-tran P.O. Box 68760, attending p signed by the a Division of Vital Records, icate has been signated by page 2 should b certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice filled in by the within 24 hours a

**Physician** /Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

9 LJ Unknown		
Part II. Other significant conditions o	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes  2  No  3  Probably  4  Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes ► No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: Nursing Ho	me 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, Cify or Town, State)
29a. Certifler 1 Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)

29c. License number

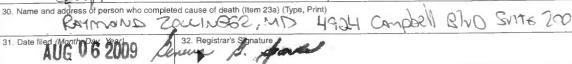
29d. Date signed (Month, Day, Year)

0

State Registrar

Medical

29b. Signatur



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Per DVK 8894 8/6/09 11
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** August 4, 2:20 а Marjorie С. Linker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Sykesville Carrol1 Fairhaven 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 □ M 2 🗓 F Yrs 1929 Maryland Mar 7, 213-26-3075 80 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examples and the political once. 1 ☐ Yes 2√2 No Director Baltimore Reisterstown MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21136 123 Glyndon Trace Drive Funeral 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' 1 □Yes 2 No 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 X Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) General Motors Parts Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Dowling Charles D. Cockey ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21093 11 Fox Knoll Court Lutherville, MD Patricia M. Brand Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-6-2009 4 ☐ Donation 5 ☐ Other (Specify) Reisterstown, MD All Saints Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 7-ans Approximate Interval Between Onset and Death 23a. art1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest In mediate Cause (Final disease or condition resulting in death) neumania Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 **D**No certificate | 1 ☐Yes 2 ☐ No Division of Vital 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tip Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi Ull DCCTGOT O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ana Idelca Sarante, MD 1645 Liberty Rd Suite 204 Eldersburg, MD 21784 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. / Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 9:20 **Physician** Рм August Donald Arthur Mealy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Lutherville Genesis Brightwood Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F Months Hours Days 90 July 9,1919 Maryland 217-07-2371 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Parkville Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3008 First Avenue 21234 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker Local Union # 734 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental Laura Richmond Robert Guy Mealy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum Penelope Smith-daughter 1205 Dahlia Court-Bel Air, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug. 7, 2009 Rosedale, Maryland Cemetery
22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8800 Harford Road Evans Funeral Chapel And Cremation Services Parkville ,MD 21234 marse 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 4 iscorse Immediate Cause (Final Physician CORONALA resulting in death) /Medical Due to (or as a consequence of): Examiner Bladder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed burial-transit Prostale Exami and Due to (or as a consequence of): physician the burial P.O. Box 68760, obs muctive Chronic pulmonary Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Dav Year 5 Other (specify) signed by the a law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 FTNO 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

541

State Registrar 31. Date filed (Month, Day, Year)

Horors.

30. Name and address proon who completed cause of death (Item 23a) (Type, Print)

7(01

32. Registrar's Signature

USPEN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 25099 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 7 Day **Physician** Neddie McFadden, РМ 29 2009 2:55 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital N/A Baltimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Min. Days Hours Months 215-74-3732 46 4-22-1963 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Photical Extractional to any injury or other traumatic event, it is Photical Extractional to any once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director YYes 2 No MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 1521 Rutland Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2√√No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: Black 3

Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Liquor Store Elementary/Secondary (0-12) 12th grade College (1-4or 5+) N/A Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elouise Montgomery Neddie McFadden ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Scott-sister 3303 Sequoia Avenue Balto, MD 21215 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Zion Cemetery 8-7-2009 Lansdown, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee H 1101 E. North Avenue Balto, la MD 21202 P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary **Physician** hour disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner DVT months Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Kidvly disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an KTN 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Dan - 06-2009 ΜD DØ065145 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Baltimore, MD. MI) 5601 Raven Lunge, Loch 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2009 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 1:39 AM 2009 Mausi 492ne 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 139 Hinore n/a If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1) Feb. 19 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours 1 ★ M 2 □ F Months Feb. 173-32-6343 65 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No PA York York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 3441 Lower Glades Rd. 17406 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No white Specify. Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Owner & President Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha M. Soloway Eugene W. Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Juli L. Montgomery/husband 3441 Lower Glades Road, York, PA 17406 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Holy Saviour Cemetery 8/7/09 York, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eu <sup>22. Name and Address of Facility</sup> Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 Inc. Approximate Interval Between Onset and Death lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or con Immediate Cause (Final disease or condition resulting in death) MINUTES Due to (or as a consequence of): 140 cardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) SCORETY Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∏Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

d other than "natural", or Items 23a or 28a-f show event, the Medical Evaniner must be notified at

Department of Health and Mental Hygiene, important: If item 27 is marked other than any Injury or other traumatic event, the Monce.

**Funeral Director** 

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria n 24 hours after death. he Funeral Director: Aft pletely filled in by the fun

Division of Vital Records, P.O. Box 68760,

Examiner a Medical Certifi

/Medic	IF FEMALE:
ysician	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown
by Ph	Part II. Other signific
Completed by Physician/M	
Be	25. Was case referred examiner?
cation: To	27. Manner of Death

within 2

State Registrar

	-
IF FEMALE:	
23b. Was decedent pregnant	
in the past 12 months?	
1 ☐ Yes 2 ☐ No	
9 🗆 Unknown	

3 Suicide

29a. Certifier

4 🗌 Homicide

29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

d cause of death (Item 23a) (Type, Print)

South Henous Street

2009

30. Name and address of person who complete

au 32. Registrar's Signature

5 Pending investigation

6 ☐ Could not be



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Nikolayev Month Day Year **Physician** 1330 PM ek sandr 30 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Seasons Hospice Birthplace (State or Foreign Country) If Under 1 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ★M 2 □ F Yrs. 12,1924 Russia Director Jan. 215-45-5496 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If tem 27 Is marked other than "natural" or home on the trainment. 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location 1 □Yes 2 No Director MD Baltimore Pikesville 10g. Citizen of What Country? 10e Street and Number 21208 USA 1450 Bedford Ave. Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify. Specify. \$ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education Professor 18. Mother's Name (First, Middle, Maiden Surname) Be ( 17. Father's Name (First, Middle, Last) Dina Liorintzevich ပ <u>Pavel Nikolayev</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1450 Bedford Ave., Pikesville, MD Wife Lyudmila Nikolaye<u>v</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Finksburg, MD Evergreen Mem. Garden's 8/1/09 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road poss Reisterstown, MD 21136 Eline Funeral Home sher 2º a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Amyotrophic Immediate Cause (Final disease or condition resulting in death) lateral selevosis months Physician /Medical Due o (or as a co sequence of): **Examiner** Sequentially list conditions, if any, leading to influentate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 1 ☐ Yes 2 ☑ No Insatrent nospice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? After 1 Z Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760,

State

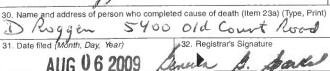
completely

within 2.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

D 35844 July 30 2009

Sute 108 Randallstown mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line b per MD 8894/ 8/6/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** effire 2009 atchett /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner N/A Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 ☑ M 2 ☐ F 50 **Director** July 12 1959 219-70-9126 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Examiner must be pullified at once." 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 ☐ No Talbot Maryland Easton 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 8657 Swan Haven 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician 12 Manufacturing 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bowling Dorothy 2 Μ. James Patchett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jackie Knopp 625 Elizabeth Street, Easton, MD 21601 (sister) Date 04 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 2009 4 Donation 5 Dother (Specify) Baltimore, Maryland 22. Name and Address of Facility 21. Sign of Funeral Service License Stallings Funeral Home, P.A. 1, Pasadena, MD 21122 3111 Mountain Road, ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, te. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1. Enter the dis shock, or heart failu Immediate Cause (Final **Physician** Ve disease or condition resulting in death) /Medical Due to (or es a consequence of) Examiner Hepatitis C Cirrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Griffying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number AU4176435E18956 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Baltimore. harisse 22 SGreene 32. Registrar's Signature Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	10000	State o	of Ma	iryland				lealth a	and M	lental Hy	giene	009	25103
			Decedent's Name (First,	Middle, Las	it)								2. Date of De	ath	V	3. Time of Death
100	Physic /Med		Lorna Ann	Roge	ers								August	3	2009	8:33 A M
	Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dec						of Death		4c. (	County of Death						
		м	28505 Pineh						Eas		T 1641- 1	0411			'albot	
	Funeral Director		5. Social Security Number 026-22-0864	6. Se	ex □M 2 <b>)</b> ∑F	7. Age	(In yrs. Ii 80	ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da 11/9/	th ly, Year) 1022	Cour	place (State or Foreign ptry) Sachusetts
	2		Usual Residence of Deced					-					11/ //	1720		
1X	/arylar	ō		ounty albot				. Town or Lo ston	cation						1	0d. Inside City Limits 1   Yes 2   No
3.4	the h	rect	10e. Street and Number						10f. Zip	Code				10g. Citiz	en of What Cour	ntry?
833 AM	Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: if item 27 le marked other than "naturel", or itame 23a or 28a-f show any Injury or other treumatic event, the Medical Examinar must be notified at once.	Funeral Director	28505 Pineh	urst (	Circle				21	601				U.S	S.A.	
<b>~</b> 3	r dea	ner	11. Marital Status		12. Was Dec Armed Fo	edent E	ver in U.	S. 13.	Was Dece	dent of H	ispanic Ori in, Mexican	gin? (Spendon, Puerto	ecify Yes or No Rican, etc.)	)- 1	4. Race - Americ Black, White,	
de	36 rs afte r', or if	by Fu	1 ☐ Never Married 2[ 3 🛣 Widowed 4 ☐ Dir		1 ☐ Yes If Yes, Gir Year or D	ve	0		1 ☐ Yes	2 <b>⊠</b> No	Specify:				Specify: Whi	.te
6	5-0C	ted	15. De	cedent's Ed	lucation			16a. Dece	dent's Usu	al Occup	ation	t of work	ing	16b. Kir	d of Business/In	dustry
OS.	21.	Completed	Elementary/Secondary (		de completed) College (		+)				during mos 1)	O HOIK	, ig			
	121 Her th		12 17. Father's Name (First, M	fiddle ( act)	2			Adm	inist	rati		de Nome	First, Middle		Custom	S
3	Maryland nd 2 should be file the and Mental Hy 27 Is marked oth treumatic event	To Be	Paul	noole, Last)			٥	Seybol	t		Lorr		rist, Middle	, maiden .	Worra	11
COGE. RS	should Mand Mand Mand Mand Mand Mand Mand Man	-	19a. Informant's Name/Re	lationship (7	Type, Print)					(Street	and Numbe	or Rura	al Route Numb	er, City or	Town, State, Zip	Code)
18	end 2		Karen Marte	ns/ Da	aughter			3651	Carr	iage	Run	Driv	e, Hil	lard,	OH 430	26
1/	Ore of He of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem	ation 3 🗍	Removal from	State	20b. PI	ace of Dispo metery, crei	nsition (Nai	ne of other plac			Date		cation - City or To	
S. V	Baltimore, semit. Pages 1 er Depertment of Heamportant: If them my Injury or other page.		4 ☑ Donation 5 ☐ Ot	her (Specify	1)		Ana	tany Gi		-	•	3/5/2			over, Ma	
OPENA	Ball permi Deper Impo		21. Signature of Funeral S	ervice Licen	500										Registr	у MD 21076
7	EN VS		23a. Part1. Enter the disease shock, or heart failure	ase, or comp	plications that o	caused each lin	the death	. Do not ent	er the mod	le of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	2	a. Me	to	sto	atic	Heo	d	& NO	eck	Car	Cer		Onset and Death
	/Medical Examiner		resulting in death)	(	Due to	(or as a	consequ	ence of):								
	0	Je.	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events		b. Due to	(or as a	consequ	ence of):								
ν	60, be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c											
	760, te be existing ysicien a	cal Ex	resulting in deathly cast	- 1	Due to	(or as a	consequ	ience of):								
	8 × 8				. d											
	Box 68 sath certifica attending ph for use as th	IN/M	IF FEMALE: 23b. Was decedent pregna	ant	23c. If yes, ou		of pregnar 2  Fetal		DEctopic p					2	3d. Date of delive	ery
	ds, P.O. Box 68 uires that the death certifica signed by the attending ph de detached for use as it	Physician/Med	in the past 12 months 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	?		nant at	time of de		Other (sp						Month	Day Year
	P.O. Ithat the de detached is		Part II. Other significant co	onditions of	ontributing to d	leath bu	it not resu	Iting in the u	nderlying (	ause giv	en in Part I		23e. Did t	obacco u	se contribute to the	ne cause of death?
	I Records, P.O. Box 68 The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as it	ed by											10	Yes 2	No 3 Prob	pably 4 Munknown
	ecord law requir as been si 2 should I	Completed											24a. Was		24b. Were auto	psy findings available mpletion of cause of
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	of Vital Physician: rthis cartifica	Be	25. Was case referred to n examiner?	nedical	Hospital:					Oth		of Deatl	(Check only	опе)		
	Jn of ding Phys	ا <u>د</u>	1 Yes 2 No		28a. Date	Inpatie		ER/Outpatier 28b. Time o		JA	4 🗆 NU		me 5 Aesi 28d. Describe		Other (Specif	ý)
	ION nding th. : Afte	ation	1 Natural 5 🗆	Pending nvestigation	(Мол	ith, Day	Year)	Injury	м	8c. Injun Work	k? Yes 2□					
	Division of Vital Records, I or Attending Physician: The law requires to alter cleath.  Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	Certification;	3 Suicide 6 0	Could not be determined	286. Place	e of Inju	ry - At ho	me, farm, str	eet, factor	y, office			28f. Location ( City or To			al Route Number,
	Dital o	Cer	20- 0-45	- Di												
	Division To the Hoepital or Attending within 24 hours after death. To the Funeral Director; Aftei completely filled in by the fune	edicai	29a. Certifier 1 Ca (Check only 2 Min one)	ininying Ph idical Exam	ninar: 27 the band man	pasis of	examinat	viedge, deat ion and/or in	n occurred vestigation	at the tin , in my o	ne, date an pinion, dea	d place, th occuri	and due to the ed at the time,	date and	and manner as s place, and due to	tated. o the cause(s)
	To th Withir To th	ž	29b. Signature and title of	certifier	FIN				29	c. Licens	e number	7.		29d. Date	signed (Month.	Day, Year)
			•		/-	<u></u>				D(	062	10		K	5-4-C	99
	Ì		30. Name and address of p	erson who	completed caus	se of de	eath (Item	23a) (Type,	Print)	2 2	16	00	ODI	to t	2015	- Acton
	SI	ate	31. Date filed (Month, Day,		32. F	Registra	r's Signat	ure	30	10	1 )	RU	X UY 1	VC	W   C	12101
	Regis		AUG 06	2009	Geneus	-	Ø. 7	park								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MORBUST 2 Kill 9 **Physician** 05:06A M ROBERT MANNING ROGERS /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Towson Center Saint Joseph Medical 8. Date of Birth (Month, Day, Year)
April 17,1925 Mary I and 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 1**X**XM 2□ F Months Days Hours 219-10-1677 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County in than "natural", or items 23a or 28a-f show the Medical Exteniner must be notified at 1 ☐ Yes 2√No Director Maryland Harford Jarrettsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3530 Glen Oak Drive 21084 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was 2 ☐ No WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married Married If Yes, Give Year or Dates: 1 □Yes XXNo Specify: White <u>6</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Broker Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clifton Shears Rogers Agnes Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Judith Harvey Rogers Wife 3530 Glen Oak Drive Jarrettsville, Maryland 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Grdns 8/8/09 Timonium, Maryland 4/□ Donation 5 □ Other (Specify) 22. Name and Address of PMntchell-Wiedefeld Funeral fome Inc Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examine physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) □Yes 2□No the detached 9 Unknown 9 Unknown ģ nas been signed b 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes ISCHEMIC BOWEL Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 No 1 ☐Yes 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No director, 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 2 Accident 1 □Yes 2 □ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760 Ö σ. Division of Vital Records, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely

Baltimore, Maryland 21215-0036

ď

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 7601 OSLER DRIVE

29b. Signature and title of certifier

32. Registrar's Signature

29c. License number

D24034

TOWSON, MARYLAND

29d. Date signed (Month, Day, Year)

1 - For State Registrar

		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death		
Physicia /Medic		Lawrence W. Reter		AUGUST 5 2009 9:20 AM						
Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Death			
		Seasons Hospice		Randal:	lstown		Baltim	ore		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign		
Director	ļ	213-20-3749 <sup>1</sup>	Yrs.			July 27	,1922	MD		
pu ,		Usual Residence of Decedent						0d. Inside City Limits		
arylar shov	_	10a. State 10b. County 10c. City, 7	own or Lo	ocation				1 ☐ Yes 2 ☑ No		
ith the Marylan or 28a-f show	cto	MD Baltimore Ro	eiste	erstown						
or 2	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	ntry?		
urs after death with the Maryla ral", or items 23a or 28a-f shov		711 Earlton Road			21136		USA			
after dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White,			
after or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 □Yes 2 ☑ No	Specify:	Specify:				
72 hours after death with the Maryland Inatural", or items 23a or 28a-f show diest Exaction on must be motified	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:				White				
72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup kind of work done	during most of wor	king   1	6b. Kind of Business/In	). Kind of Business/Industry		
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tal Figure of the file of the	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, M	naiden Surname)			
Mer Mer arke	ဥ	Chester A. Reter			Tillie					
2 sho		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ing Address (Street	and Number or Ru	ıral Route Number,	City or Town, State, Zij	Code)		
and ealth n 27		Margaret F. Reter Wife					n, MD 21136			
es 1 of H or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State	e of Dispo etery, cre	osition (Name of matory or other plac	ce)	Date 2	20c. Location - City or To	own, State		
Pag ment ant: ury c			oll (	Cremation	8/6	/09	Hampstead	MD		
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, in a invidical Exagine.		21. Sgnature of Funeral Service Licensee	2	2. Name and Addre	ss of Facility	1182	4 Reisterst	own Road		
99 <b>= 9</b> 9	Ų.	Jana & Cini	E	Eline Fund	eral Home	Reis	terstown, M	D 21136		
		23a. Part 1. Enter the disease, or complications that caused the death. hock, or heart failure. List only one cause on each line.	Do not en	ter the mode of dyin	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between		
Physician		Immediate Cause (Final	iN O	TIC HE	ANT NI	SEASE		Onset and Death		
/Medical		dispase or condition  esulting in death)  Due to (or as a consequer		110 110	na Di	DE IDE				
Examiner		b								
T +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nce of):							
cute nd ransi	Examiner	that initiated events c.								
e exe ian a irial-1		resulting in death) Last Due to (or as a consequen	nce of):							
ficate be executed physician and s the burial-transit	ica	d								
death certificate be executed e attending physician and d for use as the burial-transit	cian/Medical	IF FEMALE:								
ith ce tend	an/l	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnanc	y eath 3[	☐ Ectopic pregnand	CV		23d. Date of delive Month	ery Day Year		
e dea	sici	1 Yes 2 No 4 Pregnant at time of dea	th 5 i	Other (specify)			Month	Day real		
The law requires that the date has been signed by the bage 2 should be detached	Physic	5 II OTIKITOWIT				00 - 0111-1		1		
es th ignec	by	Part II. Other significant conditions contributing to death but not resulting	23e. Did tobacco use contribute to the cause of death?							
equir een s ould		Demonto				1 ∐ Ye	s 2 No 3 Pro	2 No 3 Probably 4 Wunknown		
e law r has be e 2 sh	ple	Congestive Heart railing				24a. Was ar	24b. Were aut	Nere autopsy findings available prior to completion of cause of		
The page	Completed	3				perform				
To the Hospital or Attending Physician: The within 24 hours after dead within 24 hours after dead or To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one				
nysic nis ce direc	To E	1   Yes 2   No Hospital: 1   Inpatient 2   EF	R/Outpatie	ent 3 □ DOA Oth	ner: 4 🗌 Nursing H	lome 5 🗌 Reside	nce 6 Other Spec	MS HOSPE		
ng Pt terth	L:u	(Adapate Day Vacal)	Bb. Time o	of 28c. Inju Wor	ry at k?	28d. Describe ho	w injury occurred	7,		
ath. r: Ai	atic	2 Accident investigation			Yes 2□No					
Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	e, farm, st	reet, factory, office		28f. Location (Str City or Town	reet and Number or Rui	al Route Number,		
al Dip	Certification:	Ballarity, etc. (ep-en-y)				ony or roun.				
ospit hour unera		29a. Certifier (Check only  Medical Examiner: On the basis of examinatio								
he H in 24 he Fi plete	edical	one) and manner stated.	ii and or n	Tivodigation, iii iiiy	opinion, death occi	arred at the time, de	ate and place, and dec			
29b. Signature and title of certifier  Deluvation  Deluvation  Deluvation  Deluvation  Superior  Deluvation  Deluv								(Month, Day, Year)		
		> Delivar & Burley		114	15931		August 5	2009		
20		30. Name and address of person who completed cause of death (Item 2	3a) (Type	, Print)			- 0			
Je V		Deborah I Burton	2835	5 SMITH	AVE 9	WITE ZO	3 Saltima	NO MO		
Sta			e of J	N						
Registr	ar	AUG 0 6 2009 Deneur B. 190	Ver							
HMH 17 Rev 1/2	001									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day 2000 8 29 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Specialty 8. Date of Birth (Month, Day, Year) 6 1918 Hosp-tel Munue If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 1**X** M 2 □ F 178-16-6842 90 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ehrem any lighty or other traumatic event, the Medical Example 2000. 10c. City, Town or Location 10a. State 10d. Inside City Limits **Funeral Director** 1 ☐Yes 2☐No Md. Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3742 McDowell Lane U.S.A 21227 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No
If Yes, Give
Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 k No þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Baker 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gus Riley Elizabeth Anderson ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3300 Kessler Ct. Balto. Highlands Md. 21227 Darlene Schneider- daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Arlington National Oct 21 2009 Arlington, Va. 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility Gonce Funeral Service P.A. 21. Signature f F heral Service Lice 4001 Ritchie hwy. Baltimore Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Keval tailure disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated asserts Examiner or Attending Physician: The law requires that the death certificate be executed Justion testina that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? es 2 K No certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fun 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D61882 08-04-2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ath Charles St. Baltimore 601 Corde

Registrar

State

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 7:03 RINGGOLD AUGUST 04 2009 NORMA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE SOHMS ITOPILINS BAYVIEW MEDICAL CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🖵 F 80 212 34 5281 Sept. 4,1928 MD Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State show r than "natural", or items 23a or 28a-f shov the Medical Examirer must be notified at Y⊟Yes 2 □ No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21206 USA 5909 Furley Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black If Yes, Give Year or Dates: δ 3 ₩Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Factory 8th laborer Pages 1 and 2 should be filed venent of Health and Mental Hygicant: If item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Cole Earl Anderson traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5909 Furley Way Balto, Md. 21206 Kimberly Stevenson (niece) permit. Pages 1 and:
Department of Health
Important: If item 27
any injury or other tro Baltimore, 20b. Place of Disposition (Name of cametery, crematory or other place) Aug. 8,2009 Garrison Forest Veteran Cem. 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State OwingsMills, Md 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DAY BACTEREMIA Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and-tran Due to (or as a consequence of): attending physician a Box 68760. Physician/Medical the If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year for 5 Other (specify) P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ğ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has certificate 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital <sup>1</sup> 2 **X** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes ၉ After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funeral Director: After the Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

V

To the I within 24

State Registrar MIKHAILIA 31. Date filed (Month, Day, Year) AUG 0 6 2009

Milhalia Lake, MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

4940 EASTERN AVENUE M.D. LAKE 32. Registrar's Signature

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

BALTIMORIE

2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8/5/2009 4:43 PM Mildred Irene Stem 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Year) 3/19/1929 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Days Hours Min Months 1 □ M 2 🛣 F 217-24-1086 80 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6514 Freedom Ave. 21784 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Nurse Mt. Wilson State 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Glenn Gertrude (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6514 Freedom Ave., Sykesville, MD 21784 Carlton W. Stem / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ebenezer UM Church Cem. 8/11/09 Sykesville, MD 21. Signature of Funeral Service License <sup>2</sup>Burrierdouge an Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 3a. Part 1 Enter the disease, or complications at caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, k, or heart failure. List only one car Imme late Cause (Final disease or condition resulting in death) Onset and Death as a correquence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Libeaus of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 9 🔲 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be routified at

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other than "natur

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27 Is marked other

r traumatic event, II

Health tem 27 I

permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other once.

Director

Funeral

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Completed

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine attending physician and for use as the burial-trar Physician/Medical certificate has been signed by the rector, page 2 should be detached 2 Completed Be After this Certification; To death. s after death.

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 25. Was case referred to medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

DEVE HOOSE

autopsy performe 1 ☐Yes 2 ☑No

24b. Were autopsy findings available prior to completion of cause of death? 2 100 1 ☐ Yes

examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DOA	Other: 4 \(\sum \) Nursing Home	5 ☐ Residence 6 AO Other (Spec
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)			. Describe how injury occurred

investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ta Streat Westhiostal MD 21157

State Registrar

Medical

29b. Signature

31. Date filed (Month, Day, Year) AHR 0 6 2009

d title of certifie

Flavio Kruter

within 24 hours a filled

To the Hospital

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 10:30 Pm Etta Virginia Sodosky 200 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Union Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 3 XXF Months 235-34-5966 88 Director July 4, 1921 West Virginia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Wedical Examiner our by notified at Maryland N/A 1 Yes 2 □ No Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 603 W.36th Street USA 21211 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Yes, Give No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify ≥ Specify: White 3XXWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emery Jackson Bowyer Alberta Bell Spour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau once. 4009 Putty Hill Ave., Baltimore, MD Edsel Dyer (Nephew) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 8/6/2009 Gardens of Faith Fullerton, MD 4☐Donation 5 ☐Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Burgee-Henss-Seitz Funeral Home, Inc. Boad Baltimore, MD 21211 23a. Part 1. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma **Physician** ta 2 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760/ burial-trar Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 pronths? 1 Yes 2X No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA Inpatient Medical Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death Date of Injury 28d. Describe how injury occurred After (Month, Day, Year) Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I

31. Date filed (Month, Day, Year) State 06 2009 Registrar

30. Name and

29b. Signature and title of certifier

traut 2. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

Calvert

Boldmore, mD 21218. arke

29c. License number

0059055

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6: D2AM alerie 4009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) 62 215-76-1971 47 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show notified at Director N/A Baltimore XXYes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be n 21213 1401 E. Oliver Street U S A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc Armed Forces? 1 ☐ Yes 2 XNo 1 Yes 2 If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 XNo Black Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4 or 5+ Disabled llth grade N/A Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Pullen Celestine Taylor ပ္ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 ar Department of Heal Important: If item 27 any Injury or ... Priscilla Taylor-Aunt 3606 Chesterfield Avenue Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pk 8-8-2009 Randallstown, MD Memorial Kina 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H B lade wane 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pira **Physician** umonia disease or condition /Medical resulting in death) Due to (o as a consequence of) **Examiner** small Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence or) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autonsy performe Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 $\square$ Nursing Home 5 $\square$ Residence 6 $\square$ Other (Specify) 1 🗌 Yes 3 No 1, Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month. Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural

the burial-transit or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760, physician use as t for the signed by be should page 2 certificate has funeral director, After this s after death filled in by the

and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

"natural",

al Hygiene. other than "

and Mental

Health tem 27 i

3altimore, Maryland 21215-0036

5 Pending investigation 6 Could not be determined

28c. Injury at Work? Injury М

1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

🕪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifie

29c. License number RES-000 29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MENCHA MMANUEZ

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

31. Date filed (Month, Day, Year)

2 Accident

4 Homicide

3 Suicide

29a. Certifier

32. Registrar's Signature

and manner stated

To the Hospital within 24 hours a To the Funeral D

completely

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		State Registrar						$C\epsilon$	ertifica	ite of	Death	1		Reg. N	lo. 👇 🔍	00	ب ک	1 1
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Funeral Director		5. Social Security N 219-28-15		6. Sex 1 □	M 2∕ F	7. Age	(In yrs. la 78	as <i>t birthd</i> ay Yrs.	Month	er 1 Year s Days	Hours	Min.	8. Date of B (Month, L Sept.	Day, Yea	1930	Coul	olace (State ntry) 1and	or Foreign
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or 28s	Directo	10e. Street and Nur	mber						10f. 2	Zip Code				10g. 0	Citizen of W	/hat Cou	ntry?	
permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Examinar must be multiped at once.		8 Suma	ac Road	1						210	60				Unite	d St	ates	
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/Medical		resulting in death)  a.  Due to (or is a consequence of):												Lyc	7			
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ath. rr. After re funera	ation:	27. Manner of Death  1	5 🗌 Pendir investi	gation	28a. Date (Mor	e of Injury nth, Day,		28b. Time Injury	of M	28c. Inju Woi 1	ry at rk? ]Yes 2[	□No	28d. Describ	e how in	jury occurr	ed		
e Hospital or Attending Physician: The law requires that the death certifing the hours after death.  e Funeral Director: After this certificate has been signed by the attending the letely filled in by the funeral director, page 2 should be detached for use as	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern		28e. Place build	e of Injury ding, etc.	y - At hor (Specify	me, farm, s	farm, street, factory, office  28f. Location (Street and Number or Rural Route Notice City or Town, State)					al Route Nu	ımber,			
spita ours neral filled		29a, Certifier	1년 e rtifvi	ng Phys	ician: To the	e best of	my knov	vledge, de	th occurr	ed at the t	ime, date	and place	, and due to th	ne cause	e(s) and ma	anner as	stated.	
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To the Hosp within 24 hor To the Fune completely fi

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 **Physician** July 21. 1:07 РМ Grant Edward Aug /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 20409 Alderleaf Terrace Montgomery Germantown If Under 1 Year 8. Date of Birth (Month, Day, Dec. 2, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 AM 2□ F Day: Hours Min. 698-10-0840 2008 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Germantown Montgomery the 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20409 Alderleaf Terrace 20874 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23: any Injury or other traumatic event, the Medical Examinat must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 x Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21X No Specify: White Completed by Specify. 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) None 0 None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theresa Mary Cull ပ Lance L. Aug 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20409 Alderleaf Terrace Germantown, MD. 20874 Lance L. Aug (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery July 24 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 East Hanover, New Jersey 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD. 20877 23a Part 1. Eprer the diseas , or complications that y used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final Week Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner (Rhabdoid) with Pulmonary Metastatic 12 Weeks Malignant Tumor Sacuration list or mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cuentially list conditions Disease Due to (or as a consequence of) Examine death certificate be executed and Due to (or as a consequence of) the attending physician a ned for use as the burial O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown signed by the ٦. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? Jas certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Tes 2 ANo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After the 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury within 24 hours after occ...

To the Funeral Director: After completely filled in by the fur 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number မ July 22, 2009 MD034283 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 111 Michigan Avenue NW, Washington D.C. 20010 Holly Meany M.D. 31. Date filed (Month, Day, Year) State 23 JUL Registrar

DHMH 17 Rev 1/2001

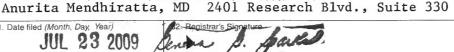
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 21, Day009 **Physician** 10:30A M Paula S. Atlas /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examine Rockville Potomac Valley Nursing Home Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0.2 / 4/24 / 13 18 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday **Funeral** 91 Pennsylvania 1 🗆 M 178-18-0197 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examiner must be notified at once. MDSilver Spring Montgomery 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20910 1006 Highland Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: 2 3₺ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Executive Secretary Arts Festival 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph H. Wohlfeld Yetta Haas ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6316 Castle Place, #300 Falls Church, VA 22044 Joel Atlas Skirble-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 X Removal from State West View Cemetery 07/24/2009 Pittsburgh, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licenses M01163 Approximate Interval Between Onset and Death Hours 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Pruneral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, To the within 2 To the I

> State Registrar

31. Date filed (Month, Day, Year) JUL 23 2009

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D38262

29d. Date signed (Month, Day, Year)

July 21, 2009

Rockville, MD 20850

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2009 Carolene 1100 AM Anthony /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days Hours 1 DM 2×21 220-34-8701 May 30, 1936 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural"; or items 23a or 28a-f show Injury or other traumatic event, it a Medical Evanture must be polified at 1 ☑ Yes 2 ☐ No Director MD Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20851 USA 510 Fletcher Place Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 TNo 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1∐Yes 2⊠No Specify: 3 Widowed 4 Divorced Black Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Domestic Worker Private Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Bernice Shields Fred Anthony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or any Anita Viola McKenzie - daughter 510 Fletcher Place Rockville,Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 27, '09Silver Spring, Md. Gates of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 3831 Georgia Avenue, N.W. 21. Signature of Ameral Service Licensee 22. Name and Address of Facility Washington, D. C. 20011 MD 278 Latney's Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Hours Acute Respiratory Failure /Medical Due to (or as a consequence of): Examiner End Stage Liver Disease Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of Exami Hepatitis C Years and burial-tran Due to (or as a consequence of): attending physician for use as the buria certificate be Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed has certificate Be Certification: To

Box 68760 P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral

arolene

							24a. Was an autopsy performed? 1 □ Yes 2 ₺ No	24b. Were autopsy findings availabl prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred	to medical					26. Place of Deat	h (Check only one)	
examiner? 1 ☐ Yes 2 🕅 No		Hospital	l: 1 <b>⊠</b> Inpatient 2 □	] ER/Outpatient	3 🗆 🗅	OA Other: 4 Nursing Ho	ome 5 Residence 6	S ☐ Other (Specify)
2 Accident	5 Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ∐Yes 2 ☐No	28d. Describe how injury	y occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e	Place of Injury - At h building, etc. (Speci	ome, farm, stree	t, facto	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )

29a. Certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI 9901 Medical Center Drive, Rockville, Md. 20850

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Year July 21, Physician Matilde Aliaga 8:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6436 Needle Leaf Drive Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day June 25, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. . Year) 916 1 □ M 2 🖺 F Months Peru 579-88-6825 93 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, If a Medical Examinating to notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6436 Needle Leaf Drive 20852 USA 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Peruvian 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 TNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 XYes 2 No Specify Specify:White ģ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Antonio Orejuela 18. Mother's Name (First, Middle, Maiden Surname)
Baldomera Tavara Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberto Aliaga/Son 6436 Needle Leaf Drive, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 23, All Souls Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Germantown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Coll 500 University lins Funeral Home Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 7 months 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Pancreatic Cancer months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) the a 1 ☐ Yes 2XXNo Ö 9 Unknown þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Insufficiency, Diabetes, Aortic Stenosis 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b rector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perlormed? Yes 212 No The 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 1∐Yes 2. No Hospital: this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred **X** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

σ. Division of Vital Records, To the Hospital or Attending Physician:

29c. License number D30375

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) July 22, 2009

30. Name and address of person no completed cause of death (Item 23a) (Type, Print)

and manner stated.

Ricardo Fernandez, MB

3301 New Mexico Avenue, #205, Washington, DC

31. Date filed (Month; Day, Registrar

Medical

29a. Certifier

29b. Signature and title of certifi

23



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #7&8 Per FH G895 9/02/09 JH
State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Health and Mental Hygiene
1- State of Maryland / Department of Department of Department of Health and Mental Hygiene
Certificate of Death

1- Department of Maryland / Department of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Allen Hortensia Turner 18, 2009 4:00 A M July/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital 01ney 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov • 27 5. Social Security Number 7. Age (In yrs. last birthday 6. Sex **Funeral** 1919 Washington, Months Days Hours Min. 578-32-8176 1 □ M 2 🕅 F Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Wedleal Event with the notified at MD Montgomery Silver Spring 1X Yes 2 No Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 3200 North Leisure World Blvd. #1016 20906 United States Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. African 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>۾</u> 3 ☐ Widowed 4 K Divorced American Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of the and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) District of Columbia Counselor 5+ 18. Mother's Name (First, Middle, Maiden Surname) Vermelle H. Turner Vernelle H. Turne 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any injury or other traumatic event Be Goodloe D. White ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Angelina Addison - friend 13110 Voelcker Ranch Drive, San Antonio, TX 78231 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 7/23/2009 4 Donation 5 Dother (Specify) Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service bicenses 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CLOSTRIDIUM PIFFICILE COLITIS DAYS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran and Due to (or as a consequence of). Box 68760, ing physician as the burial be Physician/Medical certificate attending IF FEMALE esn yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for Month Day Year 5 Other (specify) P.O. I ed by the a 9 Unknown signed by i The law requires that 23e. Did tobacco use copyribute to the cause of death? Part I). Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ a No 3 Probably 4 Unknown 1 ☐ Yes ILEUS Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury (Month, Day, Year) 5 ☐ Pending investigation he Hospital or Attendi in 24 hours after death. he Funeral Director: A pletely filled in by the fu death. 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Medic To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLNEY MD 20832 MONTGOMELY GEN. HOSP, 18101 PRINCE PHILIP DR DEBORAH STEIN D.O. 31. Date filed (Month, Day, Year) 3. Registrar's Signat State 23 2009 JUL Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1

		-	State of Maryland / Dep	partment of Health and ertificate of Death		
			Registrar  1. Decedent's Name (First, Middle, Last)	er incate or beaut	2. Date of Death	
	Physicia /Medic		Carol Jean Ames		July	23 2009 0344A
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat Hagerstown	h '	4c. County of Death  Washington
- تعدر	Funeral		Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda.	y) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	Ů,
	Director		219-60-4856 1□ M 2♥F 56 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Nov 16,	1952 Maryland
	land	ł	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits
	Mary a-f she	tor	Maryland Washington Hagersto	wn		1 □ Yes 2 No
	ith the	Dire	10e. Street and Number	10f. Zip Code 21740		og. Citizen of What Country? U.S.A.
	ns 23a	Funeral Director	323 Winding Oak Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puer		14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It a librated Examiner must be notified an once.	y Fur	1 Married 2 Married 1 ☐ Yes 2 Ma No	1 ☐ Yes 2X No Specify:	to Hican, etc.)	Black, White, etc.  Specify: White
21215-0036	hours	Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a. Dec	cedent's Usual Occupation		6b. Kind of Business/Industry
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JO.	Pages 1 nent of H int: If ite iry or ott		1 ☐ Bunal 2 ☑ Cremation 3 ☐ Hemoval from State	position (Name of rematory or other place)		
altimore,	permit. Pa Departme Important any Injury once.			: Crematory   07- 22. Name and Address of Facility 3ast-Stauffer Fune		rederick, Maryland
ä	Der Imp		James Makes	7606 Old National	Pike Boo	nsboro, MD 21713
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arre	est, Approximate Interval Between Onset and Death
102	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	precit Conce		5 years_
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	xecute and II-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
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89	ertifica ing ph		IF FEMALE:			1
Вох	eath ca attend for us	Physician/M	If the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
P.0.	t the d by the ached	hysi	1   Yes 2   No 9   Unknown			
S,	ires that the death certif signed by the attending I be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		pacco use contribute to the cause of death?
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Bec	: The law cate has page 2 s	Completed			autops perforn	y prior to completion of cause of death?
ţ	ician: Th certificate ector, pag	Be Co	25. Was case referred to medical	26. Place of De	1 □ Yes 2 eath (Check only one	
<u></u>	ding Physician: h. After this certific funeral director,		examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa			ence 6 Other (Specify)
on (	ding F h. After funera	tion:	27. Manner of Death   28a. Date of Injury   28b. Time   1		28d. Describe no	w injury occurred
Division of Vital Records,	or Attendafter death	Certification: To	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St.	reet and Number or Rural Route Number, n. State)
Õ	ital or irs after ral Dii					
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death, within 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one)  2□ Medical Examiner: On the best of my knowledge, de (Check only one)  and manner stated.	eam occurred at the time, date and pla r investigation, in my opinion, death oc	ce, and due to the courred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
		1	I michel for Mulum no	P41667		7.23.09
ふ	4-12		30. Name and address of person who completed cause of death (Item 23a) (Type Michael M. Corneik IIII) Medi	be, Print)  col Comos A.	14	Jun MO 21742
اید	Sta	te	31. Date filed (Month, Pay, Year)  32. Figistrar's Signature	cal contins that	Wajeru,	I WANT TO THE
	Registr		JUL 24 7000	1		

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cert	ificate of	Death		F	Reg. No.		
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2	Examir		4a. Facility Name (If not institution, gi				4b. City, Town,	or Location	of Death		4c.	County of Death	chise seimar
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	Funeral Director		,	1   M 2X	(In yrs. last bi		If Under 1 Year Months Days		Min.	B. Date of Birth (Month, Day Jan. 6,	v, Year)	Cour	place (State or Foreign ntry) yland
	land ow		10a. State 10b. County		10c. City, Tov	vn or Loca	ation					1	10d. Inside City Limits
	the Mary 28a-f sho	Director	Maryland Washing	ton	Boonsb	oro	10f. Zip Code				1 ☐ Yes 2 🔯 No 10g. Citizen of What Country?		
	th with 23a or ast be r	al Dii	8513 Old National	Pike			21713				U.S.		,
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			as Decedent of Yes, specify Cul			ify Yes or No- ican, etc.)		14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	in 72 ho n "natul Aedical	Completed	15. Decedent's E (Specify only highest g	rade completed)		a. Decede (Give ki life. Do	nt's Usual Occu ind of work done O NOT use retire	pation during mos ed)	st of working	7	16b. Ki	ind of Business/In	dustry
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	1 and 2 Health a em 27 is		Gary L. Nunamaker	/ Nephew	4	914 1	Harpers	Ferry	7 Road	l Shar	psbu	ırg, MD	21782
ore	es 1 g		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		20b. Place o	of Disposi ery, crema	tion (Name of atory or other pla	ace)	Da			ocation - City or To	
Baltimore,	Pages ment of I		4 □ Donation 5 □ Other (Spec			ola (	Church (	Cem. (				nsboro, M	Maryland
Balt	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Lie	Vedto o	160759	Ba:	Name and Addr St-Stau	ess of Facili	unera	1 Home	, P.	.A.	01710
	- 710		23a. Part1. Enter the disease, or con	mplications that caused	the death. Do							oro, MD	21713 Approximate
	Physician		shock, or heart failure. List onl Immediate Cause (Final	y one cau(se on each lin	e.	to a	i 1.	and the	. j.			1	Interval Between Onset and Death
4	/Medical		disease or condition resulting in death)	a. Due to (or as a	a consequence	of):	ine bi	ari	an	reare			
	Examiner			h									
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	certificate be executed ding physician and ise as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c		- 6)							
68760,	be ex cian a		The state of the s	Due to (or as a	a consequence	9 01):							
387	cate physi	Medical		<b>■</b> d									
Вох	eath ce attendi for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c, If yes, outcome p 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetal deat		Ectopic pregnand Other (specify)	ру 				23d. Date of delive Month	ery Day Year
, P.O.	that t led by detac		Part II. Other significant conditions	contributing to death bu	it not resulting	in the und	erlying cause g	ven in Part	l.	23e. Did to	bacco u	use contribute to t	he cause of death?
rds	w requires that the d been signed by the should be detached	ed by	Atrial Le	Brillatio	v.					1 🗆 Y	res 2	No 3□ Prot	bably 4 □Unknown
Division or Vital Records,	has has	Completed							<u>.</u>	24a. Was autop	sy	prior to co death?	opsy findings available impletion of cause of
ita	ilclan: Th certificate ector, pag	a)	25. Was case referred to medical examiner?					26. Place	e of Death (	Check only o		1	20,10
<u>-</u>	is dir	To B	1 Yes No	Hospital: 1 ☐ Inpatie	nt 2□ER/O	utpatient	3□ DOA Ot	her: 4□Ni	ursing Hom	e 5 Resid	lence	6 □Other (Specif	fy)
0 4	ding Pi J. After th funeral		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Inju	ıry at ork?	28	d. Describe h	now injur	ry occurred	
sio	Attending r death. ector: After oy the fune	catic	2 Accident investigation 3 Suicide 6 Could not	200				Yes 2	No				
Divi	Il or Atten after death I Director: d in by the	Certification:	4 Homicide determine	28e. Place of inju building, etc	iry - At home, f c. (Specify)	arm, stree	et, factory, office		28	Sf. Location (S City or Tow		nd Number or Rura e)	ıl Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier (Check only one)  Certifying F  2 Medical Example 1	Physician: To the best of aminer: On the basis of and manner sta	examination a	ge, death o und/or inve	occurred at the estigation, in my	time, date a opinion, de	nd place, ar ath occurre	nd due to the d d at the time,	cause(s) date and	) and manner as s d place, and due to	tated. o the cause(s)
	To the within 2 Fo the complet	Me	29b. Signature and title of dertifier	71	``		29c. Licen	se number			29d. Da	te signed (Month,	Day, Year)
2	A/2		* facul	'ahms	5		Doc	63	237	3_	7	-27-0	09
	30		30. Name and address of person who					. 102	TT	avet		(o.ex-1 1	01.7/.0
	Sta	te.	Shahid Mahmood,  31. Date filed (Month, Day, Year)					e 103	над	erstow	11, M	Maryland	21742
	Registr		JUL 27	2009 Sam	ar's Signature	100	erks						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 40 **Physician** Adams Leland Kenneth 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Hagerstown Washington County Hospital 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 13, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 1XI M 2 □ F 207-32-1400 1942 Pennsylvania 67 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location event, the Medical Examination Learned the event, the Medical Examination Learned Lear 1 Tyes 2 X No Washington Boonsboro Director Maryland 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21713 19902 Thacker Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔼 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2XINo Specify. Specify: ð White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public School Teacher permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien. Important: If flem 27 is marked other trainmairs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zahniser Alice Adams Leland Albert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19902 Thacker Drive Boonsboro, Maryland 21713 19a. Informant's Name/Relationship (Type. Print) Kimberly R. Summers / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07/29/2009 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenspe BastostadiffeforFuneral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WIE SPIRATORY PAILURG **Physician** /Medical Due to (or as a consequence of) ABRUGINOSA PNEUMONIA **Examiner** SEUDOMONAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trans and Due to (or as a consequence of): attending physician HIPPICILL OSTR'UM Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ♣ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral ( 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 ☐ Pending investigation 1-Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

Division of Vital Records, To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After To tine .

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

State Registrar 31. Date filed (Month, Day, Year) JUL 27 2009

▶ MoHAMM to

29b. Signature and title of certifier

Mohammed Aziz, MD



A212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DB#

Hagerstown, Maryland

29d. Date signed (Month, Day, Year)

0

			For State Registrar		State of Ma	ırylan			nt of Hea te of De			gieni Reg. No	0000	251	20
	Physicia	an	1. Decedent's Nam	e (First, Middle, Las							2. Date of Dea	Da	2009 Year	3. Time of 6:20	Death a <sup>M</sup>
	/Medic	al		ginia Bla	street and number)			4b. City,	Town, or Loc	ation of Death	July 1	L8,	c. County of Death		a
	Examin	er		n Hospital					hesda				lontgomer		
	Funeral Director		5. Social Security N 578-42-7	7056		(In yrs. I 84	last birthda Yrs.	y) If Unde Months		Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da SEP 25	th y, Year 19	9. Birth Cou Mar	place (State o intry) yland	r Foreign
	/land		Usual Residence o 10a. State	10b. County		10c. City	y, Town or	Location						10d. Inside Ci	
	e Mary Sa-f sh	ctor	Maryland	Montgome	ery	Ве	ethes							1 □ Yes	2 <b>X</b> No
	or death with the Marylar items 23a or 28a-f show included the continuous	Funeral Director	10e. Street and Nu 4706 Eln	<sup>mber</sup> nhirst Lar	ıe				20814	-		Uni	itizen of What Cou	es	
036		ρ	<ul><li>11. Marital Status</li><li>1 ☐ Never Marr</li><li>3 ☐ Widowed</li></ul>	ried 2 🛣 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:		S. 13		edent of Hispa edify Cuban, M 2 XNo Si	nic Origin? (Spec lexican, Puerto R pec <i>ify</i> :	cify Yes or No lican, etc.)	-	14. Race - Amer Black, White Specify: Cau		
5-0	72 ho 'natur	Completed	(Spe	15. Decedent's Ed	ucation de co <i>mpleted)</i>		16a. Dec	cedent's Usu	ual Occupation	n ng most of working	g	16b. l	Kind of Business/I	ndustry	
121	be filed within 72 hortal Hygiene. d other than "natureevent, the Mydiene.	dmo	Elementary/Seco	ondary (0-12)	College (1-4or 5- 4	+)		cher	use retired/			Pri	Lvate Cat	holic S	choo1
nd 2	e filed al Hyg other vent,	BeC	17. Father's Name	(First, Middle, Last)					18.	Mother's Name					
<u>y</u>	ould b	2	Ernest	Osborn			_			Grace	Agne		Maher		
Mar	tra		John Ant	lame/Relationship ( Thony Blac	<sup>Type Print)</sup> /Husba	and							or Town, State, Z ryland 2		
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once.		20a. Method of Dis	sposition	Removal from State			position (Na rematory or		. 08/18	/2000		Location - City or T		io
Saltin	permit. Pa Departmer Important any injury once.			5 ☐ Other (Specification of the state of th	see			22. Name a	and Address of	Facility	Servi	ce.	P.A.		La
	<u> </u>		23a Part Enter	the disease or com	plications that caused	MO09.		933 (	JIST AV	re., LL,	Silve	r Sp	oring, MI	Approximat Interval Bet	9
	Physician		shock, or he Immediate Cause disease or conditi resulting in death)	art failure. List only (Final on	one cause on each lin	rory	FAIL							Onset and HOURS	ween Death
0	/Medical Examiner		resulting in death)	•	Due to (or as a			CTTON						DAYS	
262	P +	Je.	Sequentially list contains to it cause. Enter Und Cause (Disease o	onditions, innediate	Due to (or se t			OTTON							
$\vee$	ecuter and transi	Examiner	Cause (Disease o that initiated event resulting in death)	r injury	c. SEPSIS	2 000000	ulence of).							DAYS	
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+   ©	he law requires that the death certifies has, een signed by the aftending ge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknow	2 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Feta	al death	3 ☐ Ectopic 5 ☐ Other (s				310	23d. Date of del Month		Year
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MAKCH Vital Records,	w requir	Completed							<u> </u>		24a. Was		24b. Were au	topsy findings	available
NHV tal Re	he law	dwo							-		auto perfo 1 □ Yes	ormed?	prior to death? No 1 □ Yes	completion of a	ause of
∑, /ital	<b>ysician:</b> h iis certifica e director, p∈g	Be C	25. Was case reference	erred to medical						. Place of Death					
- to	Physic this cral dire	မ	1 ☐ Yes 2 ☐ 27. Manner of Dea	<del></del>	1 X Inpatie		ER/Outpa	tient 3 🗆 C	OOA Other: 28c. Injury at		ne 5 🗌 Resi		6 ☐ Other (Spe	cify)	
2 e	Attending Physician: r death. ector: After this certific	ation	1 X Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Day	y, Year)	Injur		Work?	2 □ No			,,		
DEC	l or Attendafter deatl Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	e 28e. Place of Injubuilding, etc	ury - At h	ome, farm,	street, facto	ory, office	2	8f. Location ( City or To	Street wn, Sta	and Number or Ruate)	ıral Route Nur	nber,
3. H	To the Hospital or Attenwithin 24 hours after deatl To the Euneral Director: completely filled in by the	g	29a. Certifier (Check only one)	2 Medical Exa	nysician: To the best miner: On the basis o and manner sta	f examina	ation and/o	r investigation	on, in my opini	ion, death occurre	ed at the time	, date a	and place, and due	to the cause(	s)
	To the within 2 To the complex	Me	29b. Signature an	d title of certifier	7		-	2	9c. License nu	umber		29d. [	Date signed (Mont	h, Day, Year)	
	10		1 /k	org /H	e M.	0.		E	006	0333		01	+-18-20	709	
			30. Name and add	dress of person who	completed cause of d	leath (Iter	m 23a) (Typ	pe, Print)	old be	oneteus	vLOA	0	Reflesa	a Roo	
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	Regist	rar	J	UL 23 20	US Cerus	UK	J. 19	are							

09-05762 William Brogan

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day July 23, 2009 Physician/ 0954 hrs BROGAN JOHN Medical Examiner ILLIAM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Talbot Easton 117 East Dover Street If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Age (In yrs. last birthday) 5. Social Security Numbe **Funeral** Months Hours Feb. 10 1928 Country Directo 202 16 4602 M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b, Count any 1 XYes 2 No TALBOT s 23a or 28a-f show a MD EASTON Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Headland Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A DOVER STREET 2160 EAST 117 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 1 Never Married 2 WHITE Yes 2 X No specify: Yes, Give Yea 3 Widowed Divorce ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) BANKING BANKER 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WALDRON BROGEN LDA Be KOBERT DENNIS 19a. Informant's Name/Relationship (Type, Print ) DAUG HTEC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7/40/ ARCH WOOD ENUE Ay BROGAL 20c. Location - City or Town, Stat 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition MD. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 128/09 HESTERTOWN -EMETERY Donation 5 Other Specify. 22. Name and Address of Facility
MARVIN V. WILLIAMS. DA FUNCTED DIRECTOR
205 CREPA HERON WAY CHESTERTOWN. MD M 60625 21. Signature of Funeral Service Licenses t I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line. Death /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED ed by the attending physician detached for use as the burial Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 Probably 4 ✔ Unknown þ signed | Renal disease Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed' certificate has 2 No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Residence 6 V Other: Scene Nursing Home 5 DOA Inpatient 2 ER/Outpatient 3 1 V Yes No Medical Certification: To 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 V Natural 1 Yes 2 No Pending 2 Investigation 28f. Location (Street and Number or Rural Route Number, City Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 24, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day) r's Signature State Registra

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Physiciar Medical Examin	•	Decedent's Name			To fan					Month July 26, 2	Dav	Year	2155 hrs		
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		Prince Geo	rges Hosp	ital Center				everly				Prince George			
Funeral	T	<ol><li>Social Security N</li></ol>	lumber	6. Sex	7. Age (In y	yrs. last bi	rthday) If Ur Mon	nder 1 Year		_	th(MM		rthplace (State or gn Sierra		
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arylan	Director	10e. Street and Nu		Jward			10f. 2	Zip Code		1	0g. Cit	izen of What Cou	intry?		
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		17. Father's Name							18.Mother's Nat <b>De</b>	ne (First, Middle, borah, Me	1ro	se Thomp	oson		
212 ould be Menta marke c event	To Be	19a. Informant's N		ju Bun-Teja: ship (Type, Print)	n	1	9b. Mailing Addre	ess (Stre							
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e, P. 1 and Health	-	20a. Method of Dis		- 2 Demound			e of Disposition (Natory or other pla		emetery,	Date	20c	. Location - City of	or Town, State		
MOI Pages ent of int: II		1 X Burial 2			from State	Gate	of Heaver	n Ceme	tery 0	8/15/2009	Si	lver Spri	ng,MD		
Baltimore, permit. Pages I an Oppartment of He Important: If ite							Hinec-1	Ringld	i Funeral	Home, Inc					
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Physician Medical		failure. List of	1. Signature of Funeral Service Licensee  22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Marv  3a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
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Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should be	o Be	examiner?	2 No	Hospital: 1	Inpatient	2 🗸 EF	R/Outpatient 3	DOA	Other <sub>4</sub> Nu	rsing Home 5	Resi	dence 6 Ot	her:		
of \ng Phy	-	27. Manner of De		28a. Da	ate of Injury onth, Day, Year)	28	b. Time of Injury		jury at Work?	28d. Describ	e how i	njury occurred			
ISION Attendi	atio	1 X Natural 2 Accident		nding restigation					Yes 2 No		(0)		Rural Route Number, City		
ivision  I or Atteno after death Director: d in by the	Certification:	3 Suicide		uld not be		- At home	e, farm, street, fac	ctory, office	e building, etc.	or Town			Rural Route Number, Oity		
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the:		4 Homicide 29a. Certifier		Physician: To the		nowledge	death occurred a	t the time	date and place.	and due to the ca	use(s)	and manner as s	tated.		
in 24 H	Medical	(Check only one) 2	Medical Ex	caminer:On the bas	sis of examina	ation and/	or investigation, in	n my opinio	on, death occurr	ed at the time, da	te and	place, and due to	the cause(s)		
1800, 5 g 5 g	Mec	29b. Signature ar		and manne	er stated.	_			nse number				Month, Day, Year)		
, ,		hi	hi	, ws		O.C.M.E. July 27, 2009									
				on who completed o		h (Item 23	Ba)		MD 6105						
		Ling Li, MI		tant Medical E		2000	enn Street, B		e, MD 21201						
St Regist	ate Irai	F I	onth, Day Year	2009	Registrars	Signature	parks	4							

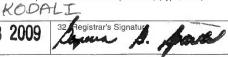
the State Registrar

RAO

(Check only one)

LEENA

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D67788

29d. Date signed (Month, Day, Year)

27.2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 Collett Mash /Medical 4c. County of Death 4a. Facility Name, (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner hestertown River Ken ester tospita If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2X F 217-44-4174 9/15/1945 PA 63 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ir than "natural", or items 23a or 28a-f showing the Modest Examiner must be notified at 1 X Yes 2 No Director MD KENT CHESTERTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21620 69 CUTTER CROSSING Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE If Yes, Give Year or Dates: δ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is merked other than "ne eny injury or other treumatic event, Its Mexit once. Elementary/Secondary (0-12) College (1-4or 5+) **GROCERY** 12 CASHIER 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM HENRY NASH ELEANOR HINKELMAN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6076 LAUREL WREATH WAY COLUMBIA, MD 21044 CHARLES COLLETT/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 7/21/09 21. Signature of Funeral Service Licensee 22. Name end Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pirator disease or condition resulting in death) /Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to him ediction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physicien: The law requires that the death certificate be executed mapho attending physician and for use as the burial-tran Due to (of as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 Yes SONo 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 065 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

4.

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

32. Registrar Signature

Monte

Year)

29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner

**Funeral** Director

show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Madical Experiment, and the modified at 72 hours after 12 should be filed w h and Mental Hygier is marked other the

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

**Physician** /Medical Examiner

permit. Pages 1 and 2 sl Department of Health an Important: If Item 27 is r any Injury or other traur certificate be executed burial-transit and attending physician the nse for the detached signed by has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. ms State

State of Maryland / Department of Health and Mental Hygiene 🗸 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 2:11 PM 2000 James Willias 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Battimore University of Many band, medical cent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 XM 2 ☐ F 7/16/2009 MD 212-40-9583 66 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director OUEEN ANNE'S CHESTERTOWN 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 100 PINE CHIP RD. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 XNo Specify: WHITE \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEVERAGE RETAIL 12 MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWARD THOMAS COLLINS, SR. FREEDA O'SHANNA GABLE ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARTA COLLINS/ SISTER 100 PINE CHIP RD. CHESTERTOWN, MD 21620 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTER CEMETERY 7/20/09 4 Donation 5 Dother (Specify) CHESTERTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 -81 of complications that Cay's ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause of tach line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease. shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Gram Due to (or as a consequence of): rod bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav in the past 12 months? 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 1 ☐ Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ဂ္ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Street Baltimore Chen 22 31. Date filed (Month, Day, Year) 32. Registras Signature

Registrar

State Registrar Margaret Akpan 6128

31. Date filed (Month, Day, Year)

JUL 2 4 2009

21215-0036

Baltimore, Maryland

P.O. Box 68760,

of Vital Records,

Division

Landover Road, Cheverly, MD. 20785

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2.5 2009 3:20  $P^{M}$ July Sadie Mildred /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Talbot Easton Talbot Hospice House 8. Date of Birth (Month, Day, Year) Nov.7, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. 1 □ M 2 🖫 F Months Days Hours Delaware Director 213-10-3885
Usual Residence of Decedent 90 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Talbot Easton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America Apt. 113 21601 640 Mecklenberg Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 1 Yes 2 Tild Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify þ 3 → Widowed 4 □ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Communications 11 HS Grad Telephone Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ John Hardester Cahall Marv Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7886 Avon Court, Easton, Maryland 21601 Jean C. Everngam Daughter Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7/29/2009 Concord, Maryland Concord Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 21. Signature of Funeral Service Licens audoph thea Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 20 Years disease or condition resulting in death) heuma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): -burial-Box 68760, attending physician Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Day jo in the past 12 months? Month Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s page certificate 2 □No Division of Vital 1 ☐Yes 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Certification: 1 Natural 2 Accident 5 Pending investigation n 24 hours after death.

e Funeral Director: Affoletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 555 32. Registrar's Signature 31. Date filed (Month, Day, Year Registrar

DHMH 17 Rev 1/2001

Amended items 23a,b&c per physician; 8/4/09 cs

1-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] []

Reg. No.

State Registrar	Certificate of Death
Decedent's Name (First, Middle, Last)	
Maywell Wade DeWitt	

**Physician** /Medical Examiner

**Funeral** Director

Director

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Completed

Be

r then "natural", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: if Item 27 is marked other then "natural; or Item only Injury or other traumatic event, it a Medical Exemption

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

Medical

31. Date filed (Month, Day, Year)

ed by the ettending physicien and detached for use as the burial-transit been signed by After thi death. To the Funeral Director: completely filled in by the f

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

within 24 hours a

124

Division of Vital Records, P.O. Box 68760,

2. Date of Death 3. Time of Death Month 2<sup>Day</sup> 2009 2:29 A M July 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Garrett 0akland Garrett County Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) X□M 2□F 215-26-7660 Sept 18 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∑Yes 2 ☐ No Mtn. Lake Park MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 113 Decatur Street 21550 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Korea White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Hwy Adm. Equipment Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Theresa Mae Frantz Arthur Thomas DeWitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 Decatur Street, Mtn. Lake Park, MD 21550 Gloria J. DeWitt, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Grove Cemetery 7/30/2009 Oakland, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Katherine 23a. Part 1. Enter the disease, or complications that ealised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia horus disease or condition resulting in death) Due to (or as a consequence of): CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of CVA Due to (or as a consequence of): IE EEMALE. 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Kores 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 

Yes 2 □ No 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09 H0064705 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4+INA State Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature Drun B. for

Dr. Richard Porter, 311 N. 4th Street, Oakland, MD 21550

**ORIGINAL** 

			For Stata Registrar	State	of Marylan		artment of H		and M		iene	009	25129
	Physici	20	1. Decedent's Name (First, Middle	, Last)						2. Date of Death Month	h Day	Year	3. Time of Death
	Physici /Medio	al	Emma Kathryn Du							July 24	, 200		8:55 A M
1	Examir	er	4a. Facility Name (If not institution		· ·	Contor	4b. City, Town, o		of Death			unty of Death Legany	1
	Funeral		WMHS-Frostburg 5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under		8. Date of Birth		9. Birth	place (State or Foreign
L	Director		188-22-3503	1 □ M 2 □ XF	83	Yrs.	Months Days	Hours	Min.	(Month, Day, 09/03/1	925	PA	intry)
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryl 1 shc	ţ	PA Somer	set Co.	Sa]	isbury	7						1 ☐ Yes 2 🙀 No
	h the	lrec	10e. Street and Number				10f. Zip Code			10	0g. Citizen	of What Cou	untry?
	23e c	Funeral Director	10149 Mason Di	.xon Hwy.			1555	8		U	ISA		
	er de:	une	11. Marital Status	Armed F		.S. 13.	Was Decedent of F f Yes, specify Cub	Hispanic Ori an, Mexican	gin? (Spe 1, Puerto i	city Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
336	al', or	þ	1 Never Married 2 Marr 3	II Yes, G Year or I	2 🔼 No ive Dates:		1□Yes 2⊠No	Specify:			Sp	ecity: Wh	ite
Ŏ	within 72 hours after death with the Maryland one. Than "natural", or Items 23e or 28e-f show he Medical Exeminat must be notified at	Completed	15. Decedent (Specify only highes		)	16a. Dece	tent's Usual Occup	oation	t of working	20	16b. Kind	of Business/I	ndustry
21215-0036	ne.	mple	Elementary/Secondary (0-12)	T	(1-4or 5+)		kind of work done DO NOT use retire	d)	t or works		'o zemor	nt Fac	town
2	l be filed w ntal Hygie ad other t	Ö	17. Father's Name (First, Middle,	(ast)		Seams	tress	18. Mothe	ar's Nama	(First, Middle, A			LOLY
Maryland	id be ental ked o	To Be		hultz						Miller			
ary	shou and M a mar umat	-	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address (Street				City or To	own, State, Z	ip Code)
Σ	and 2 ealth a n 27 ii		Mary Beachy			3833	Chestnut	Ridge					
Baltimore,	ges 1 t of He if Itsi		20a. Method of Disposition  1√2 Burial 2 ☐ Cremation	3 □Removal from	State	emetery, crer	sition (Name of natory or other pla	· · · · · · · · · · · · · · · · · · ·	_			ion - City or 1	
Ē	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department: If Item 27 is marked other than "nature!; or Items 23e or 28e-1 show any injury or other traumatic avant, in a Medical Examinat must be notified at ance.		4 Donation 5 Dother (S	pecify)	Gre		e Union			/2009 M	leyers	sdale,	PA
Ba	Depa Impo sny Ir		21. Signature of Funeral Service	. Kie.	CC03	376	Name and Addre Willi 25 Main	am Roy Stree	ve Pr	ice Fun Meyersda	eral Ie,	Home PA 15	Inc. 552
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode of dyi	ng, such as	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a Leu	kemia	- Lys	ng home	a					3 months
	Examiner			Due to	(or as a conseq	uence of); *	4						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	uence of):							
	ecuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.									
8760,	ate be executed hysician and the burial-transit	Ical E	tossining in dozin, cast	Due to	(or as a conseq	uence or):							
687	ficate g phys	edic		d							-,-		
Box	eath certifica attending pl	Ician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic pregnanc				23d	. Date of deli	,
о С	Attanding Physician: The law requires that the death certificate be executed to death. To death. Actor: After this certificate has been signed by the attending physician and extor: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	/slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of d	_	Other (specify)	,				Month	Day Year
P.O.	that the ed by detac	Physi	Part II. Other significant condition	ns contributing to d	death but not res	ulting in the u	nderlying cause giv	ven in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
Division of Vital Records,	quires in sign uld be	ed by								1 □ Ye	s 2 🗆 N	lo 3□Pro	obably 4 Únknown
000	aw require is been si 2 should b	Completed								24a. Was ar		4b. Were au	topsy lindings available
Ĕ	The lay ate has page 2	Com								autops: perform		death?	ompletion of cause of
/ita	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?	Managhali					of Death	(Check only on			
ō	Physic this crain directal	٠ <u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	_		ER/Outpatier 28b. Time of	T 3L DOA			ne 5 Reside			uty)
o	ding i th. After funer	tlon	Natural 5 ☐ Pendin 2 ☐ Accident investig		of Injury oth, Day Year)	Injury	Wo	rk? ]Yes 2 □		od. Describe no	w injury or	ccurred	
Visi	Attending or death.	Certification:	3 Suicide 6 Could r	ot be 28e. Plac	e of Injury - At he	ome, farm, str	eet, factory, office					lumber or Ru	ral Route Number,
	tal or rs afte at Dir	Cert	4   Nothicide	Duild	ling, etc."(Specif	y) 				City or Town	i, State)		
	To the Hospital or Atten within 24 hours after deati To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical	g Physician: To th Examiner: On the l	pasis of examina	wiedge, deati	occurred at the ti	me, date an	d place, a	and due to the ca	use(s) and ate and pla	d manner as	stated. to the cause(s)
	o the ithin 2 o the	Med	one) 29b. Signature and title of certifier		nner stated.		29c. Licens	se number		29	9d. Date s	igned (Month	, Day, Year)
	F 3 F 3		monne	Seels :	Mo				_				
		10	30. Name and address of person	who completed cau	se of death (Iten	n 23a) (Type,	Print)	9 9 94	- 3	1	wy	24,	-00-1
		IU	WONSOULOS	hin M	10 9	25 B	ishop h	vals l	1 R	d Cun	ube	-land	2009 d MD21502
	Sta Registr		31. Date filed (Month, Day, Year)	2009	Registrar's Signa	de Be	acted.						
	3,01			1	Nor -	1//							

09-05286 Helen F. Darney

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene 2009 25130

,	1- For State Control of War yield / Department		Reg. No.	5 2010
Physician	Decedent's Name (First, Middle,Last)		Date of Death Month Day Year	3. Time of Death
Medical Examin	Helen Frances Darney  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	July 5, 2009	1203 hrs
	20 Hillcrest	Conowingo	4c. County of Death	n
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		Date of Birth (MM/DD/YYYY) 9. Bir	
Director	220-22-5564 <sub>1 M 2</sub> X <sub>F</sub> 80	Yrs. Months Days Hours Min.	May 29, 1929 Foreign	ountry) Maryland
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City Limits
<b>8</b> 4	Maryland Cecil Conowi			1 Yes 2 X No
faryland 28a-f show	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	
the Marylanc a or 28a-f sh	20 Hillcrest Drive	21918	USA	···· <b>,</b> ·
215-0036  be filed within 72 hours after death with the Maryland mal Hygiene. Ked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	11. Marital Status 12. Was Decedent Ever in U.S. 13.  1 Naver Married 2 X Married Armed Forces?	. Was Decedent of Hispanic Ongin? ( Specia	fy Yes or No- 14. Race - Amer	ican Indian, Black,
r death	1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto Ric	an, etc.) White, etc.	
rs afte	3 Widowed 4 Divorced II Yes, Give Year or Dates:	Yes 2 X No specify: edent's Usual Occupation (Give kind of work		hite
5-0036 ed within 72 hour sygiene. other than "natu	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use retired)		industry
036 rithin and rithin	10	Waitress	Food Ser	vice
Hygi d other , the A		18.Mother's Name (Fin	rst, Middle, Maiden Surname)	
그 무용 별 호	Robert Wesley Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Lillian ailing Address (Street and Number or Rura	Alexander	7:- 0-4-1
o sh a si z i i i i i i i i i i		Hillcrest Dr., Cono		e, Zip Code)
	20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery, Da	ate 20c. Location - City or -2009	Town, State
Baltimore, permit. Pages 1 as Department of He Important: If Ite	X Bandi 2 Grandadin 6 Nemoval nom otate	go Baptist Cemetery	i i	, Maryland
Salti ermit. epartn nport		22. Name and Address of Facility R.T. Foard Funeral		, mary rand
	236. Part I. Enter the disease, or complications that caused the death. Do not ent	111 S. Queen St., R	ising Sun, MD 2	1911
Physician /Medical	failure. List only one cause or each line.		spiratory arrest, snock, or neart	Approximate Interval Between Onset and Death
Examiner	Immediate Asse (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Carbon Due to (or as a consequence of):	irdiovascular Disease		Death
	Sequentially list conditions, b			
-	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated (Disease or injury that initiated			
ted Insit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ion of Vital Records, P.O. Box 68760, tetring Physician: The law requires that the death certificate be executed teath.  Tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit	d.  UNPENDED AMENDED			
760, icate be execut physician and the burial - tra	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
ox 687 eath certific attending p		Fetal death 3 Ectopic pregnancy		Day Year
the death certification by the attending sched for use as:	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
O. B. at the de do by the stached f		ne underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
Records, P.O. i. The law requires that it ficate has been signed by page 2 should be detac.			1 Yes 2 No 3 Prot	pably 4 🗸 Unknown
cords law requests been a special				topsy findings available completion of cause of
Reco			performed? death? 1 Yes 2 ✓ No 1 Yes	es 2 No
of Vital Records, ng Physician: The law require After this certificate has been simeral director, page 2 should be recorded.	25. Was case referred to medical examiner?	26.Place of Death (Check only		
of Vi	1 V Yes 2 No Pate of Injury 29b Time		Describe how injury occurred	r: Scene
on carbing arth.	1 V Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	. Describe now injury decorred	
Division ra after death. ral Director: led in by the fi	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office building, etc. 28f	. Location (Street and Number or Ru	ral Route Number, City
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune	4 Homicide determined (Specify)		or Town, State)	
		courred at the time, date and place, and due	to the cause(s) and manner as state	ed.
To the Ho within 24 To the Fu completel	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
	What Ill - En ball h M m	O.C.M.E.	July 6, 2009	nar, bay, roar)
	30. Name a d ddress of person who completed cause of death (Item 23a)			
9		111 Penn Street, Baltimore, MD	21201	
Stat Registra				
Drilvin 17 Rev 1/200	ORIGIN	NAI	-	
OCME 2006	ORIGIN	1736	ME	

			For State Registrar	State of Ma	arylan		artmen <i>rtificate</i>			and M	ental Hy	/giene Reg. No.	- 12 12 12	0 0 7 1 0
			Decedent's Name (First, Middle, La	st)			imouri				2. Date of De		< U U-	3. Time of Death
	Physicia		Robert Go Do	an Jr.							Month 7	Day Z4	Year 200	
***	/Medic Examin		4a. Facility Name (If not institution, give University of Mary Le	e street and number)	1 Cen	ter	4b. City,		Location o	of Death	7.0		County of Dea	<u> </u>
	Funeral		5. Social Security Number 6. S			last birthday)	If Under	1 Year_	If Under		8. Date of Bi	irth		rthplace (State or Foreign
	Director	١.	219-42-4540	<b>△</b> M 2□ F	64	Yrs.	Months	Days	Hours	Min.	(Month, D 02/26/			yland
	pu ,		Usual Residence of Decedent		T.a. a									I do al la cida Otta Limita
	arylar shov	<u>_</u>	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2X No
	8a-f	Director	Maryland St. Mary	's	Val1	ey Lee	_					40.000		
	a or 2	ä	10e. Street and Number	_			10f. Zip						izen of What C	,
	s 23	eral	45254 Drayden Ro	ad 12. Was Decedent	Ever in II	C 140.1	206		ianania Ori	igin? (Cno.	nife Vac or N		ed Stat	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, the Medical Examinar, rust by notified at	Funeral	11. Marital Status 1 □ Never Married 2 🗓 Married	Armed Forces?			f Yes, spec	ify Cuba	n, Mexican	n, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi	
336	irs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I∐Yes 2	2 <b>∑</b> No	Specify:				Specify: W	hite
Ď	2 hou	ted	15. Decedent's Ed			16a. Dece	dent's Usua	l Occupa	ation			16b. Ki	ind of Business	
21215-0036	hin 7 e. an "n	Completed	(Specify only highest gra	completea) College (1-4or 8	5+)	life.	kind of wor DO NOT us	rk done d e retired	luring mosi )	t ot workin	g			
2	ygien /gien er th	Son	12			Owner	/Oper	ator					structi	Lon
g	e	Be	17. Father's Name (First, Middle, Last,	)					18. Mothe	er's Name	(First, Middle	e, Maiden	Surname)	
yla	should be and Mental s marked o	၉	Robert Graves Dea	n, Sr.					Marga	ret .	A. Cec	il		
Maryland	2 s l al	Н	19a. Informant's Name/Relationship (	Type. Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rural	Route Numi	ber, City o	or Town, State,	Zip Code)
	and Health Im 27 Ther to		Linda Dean/Wife		Tan. 5						ley Le			
0	Pages 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐	Removal from State	- 1	Place of Dispo emetery, cren			i		ate		ocation - City o	
=======================================	t. Pa rtmer rtant;		4 □ Donation 5 □ Other (Special		Şt.									Maryland
Baitimore,	permit. Pages 'Department of Important: If Ite any Injury or or once.		21. Signature Funeral Socioe Lines	Iran -	/									Home, P.A.
	40 - 40		Edward N. Brin	sfield, Jr					*				town, M	D 20650 Approximate
	Physician /Medical Examiner	2. 1	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ARD  Due to (or as	S.	uence of):								Interval Between Onset and Death
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  c  Due to (or as										
O. Box 6	the death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Feta	1 death 3 [	Ectopic pi		/				23d. Date of d Month	elivery Day Year
~ <u>`</u>	w requires that the d been signed by the should be detached	by Pr	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	tobacco u	use contribute	to the cause of death?
<b>Records</b> ,	quire en sig uld bi	g pe									1 🗆	Yes 2	No 3□1	Probably 4 🗆 Unknown
ပ္တ	law reas bee	Completed									24a. Was		24b. Were a	autopsy findings available
ř	The Is ate ha	omp									perf	opsy formed?	prior to death?	completion of cause of
Vital	×	Be C	25. Was case referred to medical						26. Place	e of Death	1 ☐ Yes (Check only	2.No	1 □Y€	es 2/2010
	Physician: this certific ral director,	To B	examiner? 1∐ Yes 2 No	Hospital: Inpati	ent 2	ER/Outpatier	nt 3 🗆 DO	Othe	) F:				6 ☐ Other (Sp	pecify)
ס ר	ig Ph ter th neral	n: T	27. Manner of Death	28a. Date of Inju	ıry	28b. Time of	2	8c. Injury Work	v at		8d. Describe			
<u>Ö</u>	endir ath. or; Af	atio	1 Natural 5 Pending 2 Accident investigation	n	y, 10ai,	many	М		Yes 2□	No				
DIVISION	al or Atte	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>	ome, farm, str	eet, factory,	, office		2	8f. Location City or To	(Street an own, State	nd Number or I	Rural Route Number,
	To the Hospital or Attending Physician: white 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	ledical (	29a. Certifier (Check only one) Certifying Pi	nysician: To the best miner: On the basis of and manner st	of examina	wledge, deat ition and/or in	h occurred vestigation,	at the tir , in my o	ne, date ar pinion, dea	nd place, a ath occurre	and due to the	e cause(s e, date and	and manner d place, and di	as stated. ue to the cause(s)
	To the within To the Comp.	Me	29b. Signature and title of certifier	///	7		290	License	e number			29d. Da	te signed (Moi	nth, Day, Year)
	10		Mula 1/1	Me My			)(	679	708	3789	3	C	17/24	12009
	on			completed cause of o									1	
_	W.		Hndrew Walk		27		Gree	ne	7+	Ba	Itam	sic.	md	21201
	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	rar's Signa	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** PM 2009 5:05 July 22 Anna Horst Eby /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington County Mennonite Home Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. June 29, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🗓 F June Maryland 218-30-9529 88 Director Usual Residence of Decedent 10d. Inside City Limits 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location The market other than "natural", or items 23a or 28a-f shot traumatic event, the "hedical Examinat mast be redfined at 1 ☐ Yes 2 No Maryland Washington County Maugansville 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21767 U.S.A. 13436 Maugansville Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 27∑No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reuben R. Eby Elizabeth M. Horst Eby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once. Seth M. Eby-nephew 17009 Broadfording Rd. Hagerstown, MD 21740 20b. Place of Disposition (Name of Reiff, Mennonite Church Cemetery or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7-25-2009 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Sumure of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** /Medical Examiner Camera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burial-1 Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown cate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No this certificate 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐ Yes 2 📜 🗖 🤇 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier соmpletely (Check only one) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0006323 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J34-2

State Registrar Shahid

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Northern

580

32. Registrar's Signature

Mahmood

Ave Hagerstown MD 21742

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20<sup>Day</sup> JYTY 200**9**a 6:30A. **Physician** Farrell Carol Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Beltsville Prince George's 4420 Samar Street 8. Date of Birth (Month, Day, Year) March 7, 1953 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 213-56-9747 7. Age (In yrs. last birthday) 56 Yrs. **Funeral** Months Days Hours Min Mary Tand 1 □ M 2 💢 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland St. Mary's Coltons Point 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20626 20990 Colton Point Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify Š 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Walden Sierra, Inc. Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley should be Ρ. Slunt Pruitt John Marcus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 27 is any injury or other trau 4420 Samar Street Beltsville, Maryland Shirley P. Denell -mother Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 7/24/2009 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licent Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 romas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Malignant neoplasm - brain **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Year ĮQ. Day 5 Other (specify) P.O. the 9 Unknown detached 9 Unknown signed by to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 XNo 1 ☐ Yes 2 🗓 No Division of Vital Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther Mother's Home 1 ∐Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide completely filled 24 hours a 1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 To the l 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 466665 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 29,<sup>Day</sup>2009  $\mathsf{JULY}^{\mathtt{Month}}$ **Physician** MARY CHRISTINE FISH 8:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES 11080 WEYMOUTH COURT WALDORF 9. Birthplace (State or Foreign Country)

MD • 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC. 25, 1922 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ Months Days Hours 217-12-8928 86 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show ns 23a or 28a-f shov MD. 1 ☐ Yes 2X No Director CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. 11080 WEYMOUTH COURT 20603 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 □Yes 2 □ 🐪 Black, White, etc. Examiner Pages 1 and 2 should be filed within 72 hours after 1 | Yes 2 | If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ò 1 ☐ Yes 2 ☐ No Specify. Specify:WHITE þ 3 ₩Widowed 4 □ Divorced natural Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NOS Elementary/Secondary (0-12) College (1-4or 5+) U.S.GOVT. PRODUCTION SPECIALIST 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN JOSEPH MONTAGUE ELIZABETH LUCILLE SPENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MARY LOU RUTHERFORD-DAUGHTER 3875 PEARL ST. WHITE PLAINS, MD. 20695 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 🕅 Cremation 3 □ Removal from State METROPOLITAN CREMATORY 8-4-09 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MD. 20646 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ichkemi Physician cyte disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myladusa Sequentially list conditions, if any, leading to infine flute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to forms a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien end for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

te Funeral Director: Af 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: Ty the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 ho

To the Fune

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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29c. License number

29d. Date signed (Month, Day, Year)

manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:30 aM 2009 July 20 Lewis Edward Guthman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours Min 1 M 2 □ F December 11, 1944 District of Columbia 217-44-6709 64 Director Usual Residence of Decedent es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Exa, it or must be notified at 1 ☐Yes 2 K No Director Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20817 6719 Brigadoon Drive Funeral . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify <u>გ</u> 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Physicist 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fern Rom Seymour Guthman မှ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6719 Brigadoon Drive, Bethesda, Maryland 20817 Adina Kole - Wife item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important; If its any Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 07/22/2009 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Anaplastic Meningioma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, requires that the death certificate be Physician/Medical use as attending p for use as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) P.O. ed by the a 1 □Yes 2 □No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown ficate has been si 7, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw certificate has autopsy performe The 1 ☐Yes 2 ☐ No 2. ■No 1 ☐ Yes Hospital or Attending Physician: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Autoria within 24 hours a er death.

To the Funeral Chector Aft

To the Funeral Chector Aft

To the Funeral Chector Aft 1 X Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier 066066 use of death (Item 23a) (Type, Print) 30. Name and address of person who comp

Registrar DHMH 17 Rev 1/2001

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3. Registrar's Signat

Year)

2009

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31. Date filed (Month. Day,

JUL

8600 Old Georgetown Road, Bethesda, MD

State of Maryland / Department of Health and Mental Hygiene 251 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day2009 Year **Physician** July 21 12:10pm Laura I. Griesmer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House 8. Date of Birth Juny 26, 1910 9. Birthplace (State or F Franklin, MA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funerai Min. Days Hours 1 □ M 2 📆 F Months 98 013-32-5220 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Exercines must be notified at 1X□Yes 2□No Director MD Gaithersburg Montgomery 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20882 USA 20308 Rosethorn Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. à Specify: White 3 

Widowed 4 

Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "1 Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilege Franz Lorne Hatfield ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If Item 27 is
any injury or other trau
once. 20308 Rosethorn Ave. Gaithersburg, MD 21882 Bonnie Boyle/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State National Crematory 7/24/2009 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Dementia /Medical Due to (or as a consequence of): Examiner Chronic Pericardial Effusion Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant The law requires that the death 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Ö been signed by the should be detached ☐Yes 2 X No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Valvular Heart Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe 1 🗆 Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 💢 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier reu 63748 7-22-09 Koud 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 East University Parkway Baltimore, MD 21218 Jocelyne Kouatchou, M.D. Date filed (Month, Day, Year) 2. Registrar's Signature State 23 2009 Registrar

09-05716 David Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hydiana

avid Green		For State	state of i	Maryland /		tificate of			viciliai i		eg. No. 200	9 25 137
Physician ledical Examine	7 Î	Decedent's Name (First, Mi					·			2. Date of Dea Month July 21, 2		3. Time of Death 1315 hrs
h :		a. Facility Name (if not institu	ition, give stre	et and number)		4			cation of Dea		4c. County of Dea	
Funanci	-	4701 Sangamore R	oad 6. Sex	7. Age	(In vrs. la	ast birthday)	Glen E		If Under 24H	rs. 8. Date of Bir	Montgomery  th(MM/DD/YYYY) 9. B	Birthplace (State or
Funeral Director	1	365-82-1147	1 <sup>™</sup> M		40	Yrs.	Months	_	Hours M	in. 02/05/	1969 Fore	ountryMichigan
any		Jsual Residence of Deceden  10a. State 10b. Cour				Town or Location						10d. Inside City Limits
faryland 28a-f show	٥	DC  De, Street and Number			wa	shingto:	10f. Zip (	ode.		т	log. Citizen of What Co	
the Mar	Director	4409 Yuma S	treet 1	VW.			2001				United Sta	ites
	ē	11. Marital Status 1 Never Married 2 X		Was Decedent Armed Forces?		S. 13. Was	Deceder s, specify	t of Hispa Cuban, M	nic Origin? ( lexican, Puer	Specify Yes or No to Rican, etc.)	14. Race - Amo White, etc.	erican Indian, Black,
fter dea	9 -		Divorced or C	Yes 2	X No		Yes 2	_			Specify: Whi	
hours a		15. Decedent's Education (S Elementary/Secondary (0-		ghest grade com		16a. Decedent during mo	's Usual C st of work	ccupation ing life. D	(Give kind o O NOT use r	of work done etired)	16b. Kind of Busines	s/Industry
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21215-0036 Mental Hygiene. Mental Hygiene. c event, the Medica	္ ရ	17. Father's Name (First, Mid Isaac Green	die, Last)					18.		me (First, Middle, ara S. S	Maiden Surname) tutman	
imore, MD 2121: Pages 1 and 2 should be fill ment of Health and Mental Is tant: If item 27 is marked or other traumatic event,	<u>o</u> [	19a. Informant's Name/Relati				19b. Mailing	Address	(Street a	nd Number o	r Rural Route Nu	mber, City or Town, Sta	ate, Zip Code) 2008
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and M Important: If item 27 is ur injury or other traumore.	Ţ	Barbara S. Gr 20a. Method of Disposition				Place of Disposi	tion (Nam			Date	20c. Location - City	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	- 1	1 Burial 2 Crema 4 Donation 5 Othe		Removal from Sta		ck Cree	k Ce	neter	y 07.	/24/2009	Washingto	on, DC
Balti permit. Departu Import injury		21. Signature of Euneral Sen	ice Licensee	4		22. N 513	ame and a	Address of	Facility Jo Sin Ave	osepn Ga e. NW Wa	wler's Sons	DC 20016
Physician	+	23a. Part I. Enter the disease failure. List only one ca	, or complicatuse on each li	ons that caused he.	the death							Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final dise or condition resulting in deat	ase a. Cai	to (or as a conse								Death
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B cuted I	EX	events resulting in death) La	d.						,			
60, are be executed hysician and e burial - transit	edic	UNPENDED  IF FEMALE:		MENDED  3c. If yes, outcor	no of pred	ID 2 DOV					23d, Date of deliv	verv
death certificate be executed te attending physician and for use as the burial - transit	ian/M	23b. Was decedent pregnant past 12 months?		Live birth Pregnant at		2 Fe	tal death	3	Ectopic pres	gnancy	Month	Day Year
	Physician/Medical	1 Yes 2 No 9	Unknown	Unknown		<u> </u>	her (Spec			las nii	tobacco use contribute	to the revenue of doubb?
P.O. B es that the d igned by the detached		Part II. Other significant co	n <b>ditions</b> cor	ntributing to deat	h but not r	esulting in the u	ınderlying	cause giv	en in Part I.	1 Ye		robably 4 Unknown
ords, F w requires to been sig	Completed by	1								24a. Was	prior t	autopsy findings available to completion of cause of
of Vital Records, ag Physician: The law requirement of the this certificate has been someral director, page 2 should I	ĕ									1 Yes	formed? death 2 No 1	Yes 2 No
Vital Reysician: The his certificate director, page	å	25. Was case referred to me examiner?  1 ✓ Yes 2 ✓ No		oital: 1 Inpatio	ent 2	ER/Outpatient			of Death (Che other 4 Nu	rsing Home 5	Residence 6 🗸 0	ther: Scene
- 3 ~ 4	은 등	27. Manner of Death	Pending	28a. Date of Inju	ury (ear)	28b. Time of I FOUND:	njury 2	8c. Injury	at Work? es 2 ✔ No	28d. Describe Subject inh	how injury occurred haled fumes from	charcoal grill
Division Hospita or Attendii 24 hour after ceath. Funeral Director: /	Certification:	2 Accident	nvestigation Could not be	Jul 20, 2009		1315 hrs nome, farm, stree	et, factory			or Tourn	Ctata\	Rural Route Number, City
Div		4 Homicide	determined	(Specify) Ve		des desth soon	med at the	time date	and place	4701 Sanga	more Road, Glen Ed	
To the Hospii within 24 hour To the Funer completely fill	Medical		Examiner: Or	To the best of n the basis of exa d manner stated	mination	and/or investiga	tion, in my	opinion, o	death occurre	ed at the time, dat	use(s) and manner as see and place, and due to	o the cause(s)
	M	29b. Signature and title of co			٨		290	License O.C.M			29d. Date signed ( July 22, 2009	Month, Day, Year)
<b>—</b> / *		30. Name and address of pe	rson who com	pleted cause of	death (Iter		7.0					
	ل	Russell Alexander	MD. As	sistant Medi	cal Exa	miner 111		Street, E	Baltimore,	MD 21201		1
Sta Regist	ate	31. Date filed (Month, Day, )	3 2009	The season	ar a Signal	. par						

State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar		Cei	rtificate of L	Death	Re	g. No 2 1 1 C	25138		
Н	Physici		1. Decedent's Name (First, Middle, Last)  Lance Wal	ter GERCKE				2. Date of Death Month	1 Day 2009 Year	3. Time of Death 11:22 a.M		
3	/Medic	al				4h City Town or	Location of Death	July 2	4c. County of Death			
P	Examin	er	4a. Facility Name (If not institution, give street and number)  2007 Maplewood Drive			Hagers			Washingt	1		
- 1	Funeral		5. Social Security Number 6. Sex			If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 Birth	pplace (State or Foreign untry)		
Đ.	Director		052-40-0569	M 2□F	59 Yrs.	Months Days	Hours Min.	Nov. 1,		York		
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City L									
re, Maryland 21215-0036	shov shov	ō	Maryland Washingt		lagerst					1 ☐ Yes 2 ☐ No		
	the N 28a-1 notifi	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?		
	3a or		2007 Maplewood Dr:	ive		217	740		U.S.A.			
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of Hi If Yes, specity Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White			
980	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	<u>م</u>	1 ☐ Never Married 2 【 <b>X</b> Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:			white		
2-0	72 ho natur dical	eted	15. Decedent's Educ (Specify only highest grade	eation completed)	I (Give	dent's Usual Occup	durina most of work		16b. Kind of Business/l	Industry		
21	within lene. than " he Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired accountar	,		tax busi	ness		
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and	ould be 1 Mental I arked of atic eve	To Be		ter A. Gercke				Elsa So	oine			
ary	S P E E		19a, Informant's Name/Relationship (Typ	pe. Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)		
	1 and 2 Health a tem 27 is		Ellen Gercke - wi	fe	2007	Maplewoo	od Drive,	Hagerst	own, Maryl	and 21740		
ore	es 1 a of He filtem		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	(	cemeterv. cre	osition (Name of matory or other plac	ce) T1-	I .	20c. Location - City or			
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)	Cec		wn Memori Par		2007		, Maryland		
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Deense			2. Name and Addres			FUNERAL HON stown, Md.			
p-	\$:		23a. Part1. Enter the disease, or compli	cations that caused the deat	-					Approximate Interval Between		
	Physician	0.3	shock, or heart failure. List only on Immediate Cause (Final	The state of the s	zuhiet	S C	10-	(1)		Onset and Death		
	/Medical	Ш	disease or condition resulting in death)	Due to (or as a consec		12 0	10~	C M C C	=	_ 6 7 / J ·		
	Examiner		Sequentially list conditions	)								
	Po tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or Injury	Due to (or as a consec	uence of):							
	ecute and I-trans	Examine	that initiated events resulting in death) Last	Due to (or as a consec	uence of):	<del>-:</del>						
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687	ertificate ing phys s as the	Medical	d									
Box	eath certi attending for use a	1 1	23b. was decedent pregnant	3c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta		□Ectopic pregnanc	v		23d. Date of del	•		
	e deat he atte led for	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of o		Other (specify)	y 		Month	Day Year		
P.0	that the de led by the a detached	Phy	9 ☐ Unknown  Part II. Other significant conditions cor	atributing to death but not res	sulting in the u	underlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	the cause of death?		
or Vital Records,	The law requires that the death ce to has been signed by the attendi age 2 should be detached for use	ed by						1 Yes 2 No 3 Probably 4 Unknown				
000	law re as bee 2 sho	Completed						24a. Was a	n 24b. Were au	utopsy findings available completion of cause of		
Ä		mo.						perforr	med? death? 2☑No 1☐Yes			
/ita	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	1		l ou		th (Check only on	e)			
or \	Physical this cral dire	မ	1 Yes 2 No	lospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie							
no	ding In. After funer	ioi	1 ☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk?  Yes 2 □ No	28d. Describe how injury occurred				
Division	deatl deatl ctor: y the	fical	3 Suicide 6 Could not be	28e. Place of injury - At h	ome, farm, s			28f. Location (St	ocation (Street and Number or Rural Route Number, ity or Town, State)			
Ö	- 9	Certification:	4 Homicide determined	building, etc. (Speci	Ty)			City or Town	i, State)			
	To the Hospital o within 24 hours aft To the Funeral D completely filled in	Medical (	29a. Certifier 1 ☐ Certifying Physical (Check only one)	sician: To the best of my kniner: On the basis of examin and manner stated.	owledge, dea ation and/or i	ath occurred at the ti investigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)		
	<b>To the</b> within 2 <b>To the</b> сотріє	Me	29b. Signature and title of certifier	2		29c. Licens			9d. Date signed (Mon			
			michael 6	hufami	MO	0 _ 0	41667		7.24	1.09		
			30. Name and address of person who co	ompleted cause of death (Ite		, Print)		1	7.24 Hajesto	_		
63	4-6		Michael Me	32. Registrar's Sign	illl	0 med	Feel (6	Mrs 1	rejes/vi	m MD		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	02. Hagistrar's Sign	B	6.41						

DHMH 17 Rev 1/2001

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Catherine Elizabeth McCormick Goldberg 22, 0635 M 2009 July 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Rising Sun Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 22, 1920 Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months 1 □ M 2/□ F Yrs 125-03-8289 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No Maryland | Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2727 Riva Road 21401 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Twelve Years Personal Residence Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bridgette Kiernan William McCormick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Frist Road, Conowingo, Maryland Valerie Owens (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 07/28/09 Crownsville, Maryland Cemetery 22 Name and Address of Facility 21. Signature of Funeral Service License Lee A. Patterson & Son Funeral Home, of marritt Perryville, Maryland 21903-0766 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gangrene Lower extrenity D-f IMONT disease or condition resulting in death) Due to (or as consequence of): erithery/ Vas cular 18arz if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzheimer's 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2□ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work?

**Physician** /Medical Examiner

permit. Pages Department of Important: If it any Injury or o once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. Interest if item 27 is marked other than "naturat", or ite any or other traumafic event, the Medical Examineary or other traumafic event, the Medical Examineary.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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death with the Maryland

Examine attending physician and for use as the bunial-transit been signed by the s should be detached has page this certificate director. After within 24 hours after death

To the Funeral Director:

or Attending Physician: The law requires that the death certificate be executed

Hospital

the

15

Division or Vital Records, P.O. Box 68760

Physician/Medical Completed by Be ို

1 Natural

Medical Certification: 4 ☐ Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 Yes 2 No

Way, Rising Sun, MD 21911

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 SertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated
2 Medical Examiner: On the basis of examination and/or investigation in more stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

COLONIAL 10(

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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WD

31. Date filed (Month, Day, Year)

32. Registrar's Signature JUL 2 4 2009

parke

Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of M	aryland / [	-	rtment of H tificate of E			ene 2 (	009	25140
	Division		1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic		Peter Boot	h Gardner					July 22,	2009		3:57 p M
, de	Examin		4a. Facility Name (If not institution,	give street and number,	)		4b. City, Town, or	Location of Death				
-			23363 Nicholson				Holly If Under 1 Year	wood If Under 24 Hrs.	D D-4 ( Di-4h		3. Time of Death 3:57 p  3:57 p  Sunty of Death  L. Mary's  9. Birthplace (State or Foreign Country)  Maine  10d. Inside City Limits 1 yes 2 No  n of What Country?  U S A  Race - American Indian, Black, White, etc.  pecify: White of Business/Industry  korsky Aircraft  Imame)  Fown, State, Zip Code) , MD 20636  Ition - City or Town, State  1 otte Hall, MD  ral Home, P.A.  wn, MD 20650  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death	
	Funeral		,	6. Sex 7. Ag 1 √2 M 2 □ F	ge (In yrs. last bir	thday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Biltin	
	Director		020-34-7993 Usual Residence of Decedent		64	110.			05/15/1	945		маіпе
	land ow		10a. State 10b. County		10c. City, Town	n or Loc	ation				1	0d. Inside City Limits
	Mary -fsh	ţ	Maryland St. 1	Mary's	Но	11y	wood					1 □Yes 2 No
	r 28a	Director	10e. Street and Number				10f. Zip Code		11	og. Citizen of	What Coul	ntry?
	h with		23363 Nicholson	Street			206	36		U	S A	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp. Mexican, Puerti	pecify Yes or No-			
9	or ite		1 ☐ Never Married 2X Marri				☐Yes 21 No	Specify:	or mounty overly		fv.	
93	ours iral",	Completed by	3 Widowed 4 Divorced	Year or Dates:							Wh	
5-(	72 h "natu	ete	15. Decedent (Specify only highes	s Education t grade completed)	16a.	. Deced (Give )	lent's Usual Occupa kind of work done d OO NOT use retired,	ation <i>Juring most of wor</i>	king	16b. Kind of B	susiness/in	dustry
121	vithin	m d	Elementary/Secondary (0-12)	College (1-4or 5+	5+)		Business			Siko	rekv	Aircraft
2	iled v Hygie ther i		17, Father's Name (First, Middle, I	·			Dustiless		ne (First, Middle, M			Afferait
an	of be	) Be		dner				Marie	Boot	h		
<u></u>	d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic event, Ire M.	ပ္	19a, Informant's Name/Relationsh		196	. Mailin	g Address (Street a	and Number or Ru	ral Route Number	City or Town	, State, Zij	code)
$\geq$	nd 2 s lith al 27 is r trau		Pamela Gardner/		2	2336	3 Nichols	on Stree	t, Holly	wood,	MD 20	)636
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show then traumatic event, if a Medical Examiner must be notified at		20a. Method of Disposition		20b. Place o	f Dispos	sition (Name of natory or other place					
JUO	Pages ent o nt: If I		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		<del>)</del>		1d–Echols		5/2009	Charlo	tte H	Hall, MD
ij	permit. Pages 1 Department of I Important: If Ite any Injury or ot once.	l	21. Signature of Funeral Service L									
Ba	Depar Impol any ir		Kyle Simons	M01206		2	2955 Holl	Lywood Ro	l., Leona	rdtown	, MD	20650
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do	not ente	er the mode of dyin	g, such as cardia	or respiratory arr	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	M	o-tast	24	c Rano	vestiz	Cdr	cer	- 1	Onset and Death
	/Medical		resulting in death)	Due to (or as	s a consequence	of):	-	, ,				
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	D #	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or er	s a consequence	of):					- 21	
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to for a	s a consequence	of):						
60,	ficate be executed physician and s the burial-transit			Due to (or a	s a consequence	01).						
87	cate physi the b	dical		d								
9 ×	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy					334 D	ate of deliv	Jory
Bo	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death at time of death		Ectopic pregnancy Other (specify)	У				
o.	ires that the de signed by the a be detached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown			dinor (apoony) _					
σ.	that ned by deta	/ Ph	Part II. Other significant condition	ns contributing to death	but not resulting i	n the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	ntribute to	the cause of death?
rds	puires n sigr ild be	d by							1 □ Ye	es 2 🗆 No	3☐ Pro	bably 4 Unknown
00	w require s been si should b	Completed							24a. Was a		. Were aut	opsy findings available
R	sician; The law certificate has triector, page 2 s	mo							autops perfori 1 □ Yes	ned? 2. No	death?	
ta	an; tifica tor, p	Be C	25. Was case referred to medical	1				26. Place of Dea	ath (Check only on		10100	2 5110
>	Physici this cer al direc		examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpa	tient 2 ER/O	utpatier	nt 3 DOA Oth	er: 4  Nursing H	lome 5 Resid	ence 6 🗆 O	ther (Spec	ify)
0	Jing Ph h. After th funeral	Ľ.	27. Manner of Death 1 → Natural 5 □ Pending	28a. Date of In	jury 28b.	Time of Injury	28c. Injur Worl	y at </td <td>28d. Describe he</td> <td>ow injury occu</td> <td>irred</td> <td></td>	28d. Describe he	ow injury occu	irred	
Ö	endir ath. or: Af	atic	2 Accident investig	ation			M 1 🗆	Yes 2□No				
ξ	I or Attencafter death Director:	Certification: To	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 28e. Place of Ir building, 6	njury - At home, fa etc. <i>(Specify)</i>	arm, str	eet, factory, office		28f. Location (S City or Town	treet and Nun n, State)	nber or Ru	al Route Number,
	ital or las af		N .						V	- (-)		-1-1-1
. Box 68760, Baltimore, I	Hosp 24 hou Fune tely fi	ical	(Check only 2 edical	Examiner: On the basis	of examination a	je, deat nd/or in	h occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the durred at the time, d	ause(s) and i late and place	manner as e, and due	to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	one) 29b. Signature and title of certifier	and manner s		-	29c. Licens	e number		29d. Date sign	ed (Month	, Day, Year)
•	5 <u>7</u> ≦ ⊼	_	- San San San San San San San San San San	2			Da	204.2		71	541	2009
	14		30. Name and address of person	who completed cause of	death (Item 22a)	(Type	Print)			/ 1 4	× 1/	(,
_	VIV		1/ 37	10 28103	Three	1 Spal	thrd S	Lite 101	Mach	enics.	ille	MD 20659
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pegis	trar's Signature		/		1.1201			-
	Registr		JUL 28	3 2009	va B.	4	arke					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** 31,  $\mathbf{A}_{\mathsf{M}}$ 5:30 John David Gibson, Jr. July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 37694 Jack Gibson Road St. Mary's Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F 217-42-8033 Director 66 November 1,1942 Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Avenue the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be filed within 72 hours after death with 37694 Jack Gibson Road 20609 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Brick Mason 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic ev John David Gibson, Sr. Mary Dora Morris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue, MD 20609 Phyllis Ann Gibson / Wife P.O. Box 252 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date August 3 1 ■ Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) Bushwood, Maryland Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 21. Sum ture of Funeral Service ichael \* 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence offs certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. attending physiciar Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No the detached 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 \( \text{Yes} \) 2 \( \text{No} \) Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \subseteq \text{ Nursing Home} \) 5 \( \subseteq \text{ Residence} \) 6 \( \subseteq \text{ Other (Specify)} \) 1 🖺 Yes 2 **N**0 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deat e Funeral Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00 July 31, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mukhtar Hassan, M.D. 25500 Point Lookout Drive Leonardtown, MD 20650 31. Date filed (Month, Day, Year) State JUL 3 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** ROBERT KAHLER HACKMAN 2009 JULY 20, 05:20 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** KENT HERON POINT CHESTERTOWN If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Month, Day, Year, 2/21/1923 1 XM 2 ☐ F 193-12-5782 Director 86 PAUsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It a Medical Examinar must be notified at Director 1 XXYes 2 □ No KENT CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 402 HERON POINT Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 2 Yes 2 No 19/12 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1942-1 □Yes 2 No 2 If Yes, Give Year or Dates: Specify: 3 Widowed 4 ☐ Divorced WHITE 55 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 SALES MANAGER CHEMICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM HUBER HACKMAN MAMIE MOYER ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHERINE LEVENGOOD/DAUGHTER PO BOX 607 CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION: 7/21/09 STEVENSVILES, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 21. Signature of Funeral Service License 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMINIA days /Medical Examiner ears =ND-STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Year Day 5 Other (specify) P.O. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a. Was an autopsy certificate | 1 □Yes 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Natural 2 Accident 5 Pending investigation To the Funeral Director: Aft To the Funeral Director: Aft 1 ☐ Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State

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Registrar
DHMH 17 Rev 1/2001

Speer Rd. Chestertown, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Noble

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	State of Maryland / Dana	rtmant of Haalth ar	nd Mantal Hygiana

			For State Registrar	State	of Mary	yland / Dep <i>Ce</i>	artment of ertificate o			ental Hy	gien Reg. N	200	9 2	5143
	Physici /Medic		1. Decedent's Name (First, Mic Kar1 (		Hartma	nn				2. Date of De Month July 2	D	ay Yes 2009		me of Death
	Examir		4a. Facility Name (If not institu	tion, give street and		<del></del>	4b. City, Town		n of Death		40	c. County of D	eath	
Ī	Funeral Director		Andrus Hous  5. Social Security Number	6. Sex 1 <b>X</b> M 2		In yrs. last birthday Yrs.	Bethes If Under 1 Yea Months Day	r If Und		8. Date of Bi (Month, D	rth ay, Year	7	Birthplace (S Country)	State or Foreign
	D		Usual Residence of Decedent 10a. State 10b. Cour	nty	10	Oc. City, Town or L	ocation			June 2	1 و1	921	Jerman	ide City Limits
	ne Maryl 18a-f sho	ector		gomery		Chevy Cl	nase							Yes 2□No
	th with th	<b>Funeral Director</b>	10e. Street and Number 4515 Willard	Ave # 20	04S		10f. Zip Code 20	315				itizen of What	Country?	
036	72 hours after death with the Maryland natural", or items 23a or 28a-f show then Exa, it are must be notified at	<u>م</u> ا	11. Marital Status  1 ☐ Never Married 2 ☑ M 3 ☐ Widowed 4 ☐ Divorce	arried Armed	ecedent Eve I Forces? es 2 No Give or Dates:	1938- 1942	Was Decedent of If Yes, specify Cu			cify Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify:		an,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exacting traumatic event, the Medical Exacting traumatic and once.	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12 12	ent's Education hest grade complete Colleg	e (1-4or 5+)	(Give	edent's Usual Occ e kind of work don DO NOT use reti Contract	e during m red)	ost of workin	ng		Kind of Busine		rv
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Baltimore, Maryland	es 1 and of Healti if item 27 or other t		Dorothy K. Ha  20a. Method of Disposition  1 □ Burial 2 ☑ Crematio		:	4515 20b. Place of Disp cemetery, cre	Willard osition (Name of matory or other p			S Chev		nase, M Location - City		
altim	mit. Pag partment portant: I y Injury c		4 □ Donation 5 □ Other  21. Signature of Funeral Servi	(Specify)		National 2	Cremato 2. Name and Add	ry ress of Fac	7-22-	09 ph Gaw	Fal vler	1s Chui	ch, V	a
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4	Physician /Medical		shock, or heart fail re. L Immediate Cause (Final disease or condition resulting in death)	ist only one cause on a. Pne	on each line. e <b>umoni</b> a									al Between and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	bAcu	te Rer	nal Failu	re						3 W	eeks
68760,	icate be executed physician and s the burial-transit	edical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nentia to (or as a co	onsequence of):							4 W	eeks
O. Box	ath certif nttending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 🗆 Li 4 🗆 P	outcome of point of the contract of the contra	Fetal death 3	☐ Ectopic pregna ☐ Other <i>(specify)</i>					23d. Date of Month	delivery Day	Year
rds, P.	quires that the de en signed by the a uld be detached f	þ	Part II. Other significant cond			ot resulting in the u	underlying cause (	jiven in Par	t 1.			use contribut		e of death? 4 <sup>™</sup> Unknown
al Reco	i <b>cian:</b> The law requir certificate has been s ector, page 2 should	Completed								24a. Was auto perf 1 □ Yes	psy ormed?	prior death	to completio	dings available n of cause of
of Vit	ding Physician: The Int. After this certificate hit funeral director, page	n: To Be	25. Was case referred to medi examiner?  1 ☐ Yes 2★ No  27. Manner of Death	Hospital: 1	ate of Injury	2 ☐ ER/Outpatie	IN 3 LI DOA	ther: 4 🗆	Nursing Hon	(Check only ne 5 ☐ Res	idence	6 KI Other (S	sst. I	Living
Division of Vital Records,	r te r	Certification: To	3 ☐ Suicide 6 ☐ Cou	stigation	ace of Injury	ear) Injury  - At home, farm, st  Specify)	M 1	□Yes 2		8f. Location City or To	(Street a	and Number of te)	Rural Route	Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certifier (Check only one)	ving Physician: To at Examiner: On the and n	the best of me basis of ex	amination and/or i	th occurred at the nvestigation, in m	time, date opinion, c	and place, a leath occurre	and due to the	e cause , date ai	(s) and manne nd place, and	r as stated. due to the ca	iuse(s)
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	13	-	30. Name and address of person				Print)		4 2001	5	Jul	y 21, 4	-007	
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2009 25144

Jam	es Hamilton,	1-	State of Maryland / Do	Certificate of	Death		Reg.	No.	3. Time of Death	
	Physicia	ın/	eqistrar . Decedent's Name (First, Middle,Last)				Date of Death Month July 29, 200	ay Year	1727 hrs	
Med	dical Exami		JAMES PEARSON HAMILTON	,JR.	b. City, Town, or Loc		July 29, 200	4c. County of De	eath	
			Civista Medical Center LaPlata					Charles		
	Funeral		. Occidi Occurity Hambol	yrs. last birthday)				IF.O	Birthplace (State or reign	
	Director		217-46-7692	56 Yrs.	Months Days	Hours Min.	7-9-	1953	Country) MD •	
			Jsual Residence of Decedent	. City, Town or Locati	00				10d. Inside City Limits	
	w any		MD • CHARLES		E PLAIN	S			1 Yes 2 X No	
	yland a-f sho t once	휘	Oe. Street and Number		10f. Zip Code		100	. Citizen of What	Country?	
	he Mau or 28	Director	9640 RANDALL DRIVE		2069			J.S.A.		
1	death with the Maryland or items 23a or 28a-f show must be notified at once.	la l	11. Mantal Status 12. Was Decedent Eve	r in U.S. 13. Wa	s Decedent of Hispa es, specify Cuban, N	nic Origin? (Spe Mexican, Puerto F	cify Yes or No- tican, etc.)	14. Race - A White, e	merican Indian, Black, tc.	
10	death or iten	Funeral	1 Never Marned 2 X Married 1 X Yes 2	No	Yes 2X No			Specify: W]	שדיייני	
	s after ral",	à	3 Widowed 4 Divorced or Dates: 1 9.73  15. Decedent's Education (Specify only highest grade complete)	ted) 16a Deceder	nt's Usual Occupation	n (Give kind of wo		16b. Kind of Busin		
	2 hour "natt	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	during m	nost of working life. D	O NOT use retire	ed)	CARPEN	TERS UNION	
	5-0036 lled within 7. Hygiene. J other than	힐	11	CAL	RPENTER	.Mother's Name	(First Middle M		TERE CITED	
	15-0 illed w Hygie d other	ပို	17. Father's Name (First, Middle, Last)  JAMES P. HAMILTON, SR.			MARY _L(				
	2121 ould be fi Mental marked	o Be	19a. Informant's Name/Relationship (Type, Print )	19b. Mailin	ng Address (Street	and Number or R	ural Route Num	ber, City or Town,	State, Zip Code)	
	MD 2 d 2 shou lth and 1 n 27 is r	-	SHERRI HAMILTON-SPOUSE		) RANDAL			PLAINS 20c. Location - C	MD. 20695	
	e, N I and Health Fitem		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	20b. Place of Dispo crematory or o	ther place)	l l	Date			
	Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		4 Donation 5 Other Specify:	ROPOLITA			-5-09	ALEX.,	VA	
	Salti ermit. Pepartn mports njury o		21. Signature of Funeral Service Licensee M0047		Name and Address of RAYMOND	FUNERAI	SERV	ICE,P.A	•	
	Physician		23a. Part I. Enter the disease, or complications that caused the	e death. Do not enter	A PLATA the mode of dying, s	such as cardiac or	r respiratory arre	est, shock, or hear	Approximate Interval Between Onset and	
	/Medica	l	failure. List only one cause on each ine.  Immediate Cause (Final disease a. Atheroscle						Death	
	yamine		or condition resulting in death)  Due to (or as a consequence)							
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	Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the processes the hind is the Finneral Director: After this certificate has been signed by the attending physician and the Finneral Director: After this certificate has been signed by the attending physician and	Medical	X UNPENDED AMENDED 23a,	,27,perME,	g894 8/1	0/09 TT				
	760, cate be	Med	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the		Fetal death 3	Ectopic pregna	ancv	23d. Date of d Month	lelivery Day Year	
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	<b>ital</b> siciam is certi	on Be	25. Was case referred to friedical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatien	t 2 🗸 ER/Outpatie	ent 3 DOA	Other Nursi	ing Home 5	Residence 6	Other:	
	of Ving Physical After this	≅   ⊢	27 Manner of Death 28a, Date of Injury	y 28b. Time (		ry at Work?	28d. Describe	how injury occurr	ed	
	ion tendir eath.	the 12	1 XNatural 5 Pending 2 Accident Investigation			Yes 2 No	28f Location	(Street and Number	er or Rural Route Number, City	
	Division of Vital Records, tal or Attending Physician: The law requirers after death.	Certification:	3 Suicide 6 Could not be determined (Specify)	ury - At home, farm, s	treet, factory, dince t	bulluling, etc.	or Town,			
	ospita hours			knowledge, death or	ccurred at the time, d	ate and place, ar	nd due to the ca	use(s) and manner	as stated.	
	Division To the Hospital or Attendit within 24 hours after death. To the Functal Director: /	Modical	(Check only one)  2	ination and/or invest	igation, in my opinior	n, death occurred	at the time, dat	e and place, and d		
	To To	S   S	29b Signature and title of certifier		29c. Licens			29d. Date sign	ed (Month, Day, Year)	
1			( authorite		0.C.	.M.E.		July 30, 20		
,			30. Name and address of person who completed cause of de Laron Locke MD. Assistant Medical Exa		enn Street, Balti	more, MD 21	201			
11		C	32 Pegistrar		4			1		
	Rec	Stat sistra	MUC 0 6 2000 /2	our B.	Barker					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 JULY **Physician** 17, 11:45 A MARY ELIZABETH JONES /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner KENT CHESTERTOWN CHESER RIVER MANOR If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 4/26/1920 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours Min MD 89 Director 214-28-3109 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location Show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Event over that by notified at once. Director 1 XYes 2 No KENT ROCK HALL MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21651 21235 CHESAPEAKE AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: WHITE β 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING MANUFACTURING CLOTHING TRIMMER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY ELLEN BURGER WILLIAM ELBURN ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25350 WORTON LYNCH RD. WORTON, MD 21678 PAUL W. JONES/ SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/22/09 ROCK HALL, MD WESLEY CHAPEL 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Deiko 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Failsor Immediate Cause (Final disease or condition resulting in death) HEANT RETURN **Physician** YUM /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 □Yes 2 □ Mo been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Division of Vital Records, 2 1 🗌 Yes 2 1 No 3 Probably 4 Unknown cate has been s page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? To the Hospital or when within 24 hours after death.

To the Funeral Director: After this certificate har wholetely filled in by the funeral director, page? autopsy perform 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ Mo 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of der 29c. License number

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

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MO 32. Registrar Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Physician   Compared to the provided of the	09-05553 Michael Frank II	amo	Please Type or Print in Black I				
The proposed of the proposed o	viichaei Frank J						2009 2514
Michael Prank James, Jr.  Michael Prank James, Mother Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Jr.  Michael Prank James, Mother Prank James, Jr.  Michael Prank James, Jr.  Mich	Dhymini		Registrar	Timeate of Be	<u> </u>	2. Date of Death	3. Time of Death
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20   20   20   20   20   20   20   20	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday) If	Under 1 Year If Under	24Hrs. 8. Date of Birth	
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29b. Signature and title of certifier  O.C.M.E.  July 16, 2009  30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State  31. Date filed (Month, Day Year)  32. Registra's Signature	lospit I hour uners		29a Certifier		at the time, date and his		
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O.C.M.E. July 16, 2009  30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day Year)  32. Registrar's Signature	To with	Med	and manner stated.				
30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day Year) 32. Registra's Signature		~	Paled & W				
Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filed (Month, Day Year) 32. Registrate Signature			I and outhers, me	12m (22n)	1		
State 31. Date filed (Month, Day Year) 32. Registra's Signature	10.4				Penn Street. Baltim	ore, MD 21201	Ţ
Registrar JUL 2 4 2009 Reven B. Jack		tate					
	Regis	trar	JUL 2 4 2009 Denus B. A	parket			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician M 2009 0015 13 July Ruza Majok Kuwang /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F 1948 January Sudan Director 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County her must be notified at 1 ☐ Yes 2K No Directo Bowie Prince Ceorge's 28a-f Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō death with 23a 12403 Chasemount Court 20720 Canada Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, or items 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 ⊠ If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 🖾 Married Maryland 21215-0036 d other than "natural", or i 1 ☐ Yes 2 🖾 No þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 6 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental File is marked ott Be ည Philmon Majok Kuwang Athiang Jang Department of Health and Important: If item 27 is ma any Injury or other trauma. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ashoul Martin Malwal - Daughter 12403 Chasemount Court, Bowie, Maryland 20720 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) George Washington Cemetery 07/19/2009 Adelphi, Maryland 22. Name and Address of Facility 21. Signature of Eunore Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Peri heal Cancer /Medical Due to (or as a consequence of): Examiner Bowel Perforation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Peritonitis burial-trar Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical Respiratory Failure 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 No P.O. ned by the a 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 cate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Sepsis Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this I or Attending Platter death.

Director: After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I

State Registrar 29b. Signature and title of certifier

Kshama Carg, M.D., 1500 Forest Clen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D60826

29d. Date signed (Month, Day, Year)

July 14, 2009

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 21 21 2009 **Physician** July Brenda Joyce Kelley 08:10 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 32 E1k Chase Drive
5. Social Security Number 6. Sex Elkton Cecil Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Year Min 1 □ M 2 X Months Days Hours 213-58-2762 58 May 5, 1951 West Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 X Yes 2 □ No Director Maryland Ceci1 E1kton 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 32 Elk Chase Drive 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dewey Lee McClanahan Wilma Green ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Thomas Kelley / Spouse 32 Elk Chase Drive, Elkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
North East Methodist
Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State  $J_{2009}^{11} = 27$ North East, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Syears 15 disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bus to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) P.0. ed by the a s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an certificate has birector, page 2 sl autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife 902 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21921 Elkton 3 % 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

,			For State Registrar	State of Mar	yland		rtment of H				giene Reg. No.	009	25149
	Physicia /Medic		1. Decedent's Name (First, Middle, La Olive Mar	ie Kendall						2. Date of De Month July	Day 31	Ye ar 2009	3. Time of Death 11:35 P
	Examin		4a. Facility Name (If not institution, gi  Reeders Memori				4b. City, Town, or	Location on sbc				inty of Death	ington
	Funeral Director		219-20-4787	Sex 7. Age (		st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da March 2	th ay, Year) 26 <b>,</b> 1928	Cour	place (State or Foreign ntry)  Ty land
1	Maryland -f show ied at	tor	Usual Residence of Decedent  10a. State 10b. County  Md. Wash	ington	0c. City,	Town or Loc	cation nithsburg					1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	n with the i3a or 28a st be notif	al Director	10e. Street and Number 11739 Crystal	Falls Dr.			10f. Zip Code	1783			10g. Citizen	of What Cour	ntry?
e 14. 5-0036	permit. Pages 1 and 2 -hould be filed within 72 hours after death with the Maryland Department of Health and Martal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 □Yes A□No If Yes, Give Year or Dates:			Vas Decedent of Hi fYes, specify Cuba ☐Yes 2 X No			pecify Yes or No Rican, etc.)		Race - Americ Black, White, ecify:	
Olive M 21215-00	within 72 hou giene. r than "natur, the Medical E	Be Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5+)		(Give life. L	lent's Usual Occupi kind of work done o DO NOT use retired IOMEMAKET	ation during mos d)	st of work	ing	16b. Kind o	of Business/In	dustry
l, and	2 hould be filed vand Mantal Hygis is marked other at matic event, the	To Be C	17. Father's Name (First, Middle, Las UnKnown	t)						e (First, Middle Prine E			man
Kendal	and 2 ho lealth and m 27 is ms her trau ma		19a. Informant's Name/Relationship Clyde R. Kendall			11739	g Address (Street a) Crystal	Fall	ls Di	.Smith	sburg,	Md. 21	783
Name: Ke	E. Pages 1 tment of H tant: If iter jury or ott		20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec	ify)	20b. Pla cer Smit		sition (Name of natory or other plac natory or other place of Cremat	i	lug. 200	3, 09		on - City or To	
ild Bal	permit. Departr Imports any Inju		21. Signature of Funeral Service Lice	tovio	MO1	414 J.	Name and Addres	Fun€	ral	Home $S_1$	mithsh	radbury urg Md	Ave. . 21783 Approximate
0	Physician /Medical Examiner		Jan 2 Fire Pe disease, or cor Ass., or blant failure. List only fine diate Cause (Final disease or condition resulting in death)	nplications that caused the cause on each line.  a. Due to (or as a control of the control of th	vohe	ence of):	faulton	ig, such as	s cardiac	or respiratory a	arrest,		Interval Between Onset and Death
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58760,	ficate be executed physician and s the burial-transit	ical	resulting in death) Last	Due to (or as a d	r b	efferd	ent Dea	filis	Me	lleters			YEARY
.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal c	death 3	Ectopic pregnanc Other <i>(specify)</i>	у			23d	. Date of deliv Month	ery Day Year
rds, P	v requires that the defective signed by the should be detached	þ	Part II. Other significant conditions	contributing to death but	not result	ing in the ur	nderlying cause give	en in Part I	l. 			contribute to t lo 3 ☐ Pro	he cause of death?
Division of Vital Records, P.O	: The law re cate has bee , page 2 sho	Completed								24a. Was auto perf 1 □ Yes	opsy ormed?	4b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
V.	/sician s certifi director	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient	 1 2∏E	R/Outpatien	nt 3 DOA Oth	1.		th <i>(Check only</i> ome 5  Res		Other (Speci	fv)
ion of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has sompletely filled in by the funeral director, page 2 s	Certification: To	27. Manner of Death 1	28a. Date of Injury (Month, Day,		28b. Time of Injury	28c. Injur Worl			28d. Describe			
Divis	ital or Atturs after de ral Directo		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	d 28e. Place of Injury building, etc.	(Specity)					City or To	iwn, State)		al Route Number,
	e Hosp 124 hou e Funei iletely fii	Medical	29a. Certifier 1- Certifying F (Check only one) 2  Medical Exa	Physician: To the best of aminer: On the basis of e and manner state	examination	ledge, death on and/or in	n occurred at the til vestigation, in my c	me, date a opinion, de	ath occu	, and due to the rred at the time	e cause(s) an , date and pla	d manner as ace, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				29c. Licens				29d. Date s	igned (Month,	Day, Year)
			30. Name and address of person who	o completed cause of dea	ath (Item 2	23a) (Type,		4656			Hug	131	2007
		1	Dr. Ghazala Qadi	r 20311 La	ppans	s Road	d, Boonsb	oro,	MD	21713	301-	432-84	70
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	o Gigitatu	A.	parked						

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed
within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

			For State of Mary  1 - State Registrar	land / Departr/ <i>Certifi</i>	ment of He <i>licate of D</i> e			iene <sub>eg. No.</sub> 200	9 25150
	Dhuaisi		1. Decedent's Name (First, Middle, Last)			2.	Date of Deat Month	1	3. Time of Death
1	Physici /Medio			ffey			uly 28	, 2009	7:00 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)  Egle Nursing Home		City, Town, or Lonaconi			4c. County of Allega	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	n yrs. last birthday)	Under 1 Year		Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		218-12-5730 1□ M 2□xF 84  Usual Residence of Decedent	Yrs.	Ontino Dayo	N	lov. 20		Maryland
	yland now			c. City, Town or Locatio	on				10d. Inside City Limits
	e Mar Ba-f sh	Director	MD Allegany	Westernp	ort				tx⊒t⁄es 2 □ No
	ath with the Marylan 23a or 28a-f show ust be notified at		10e. Street and Number 320 Maryland Avenue	10	Of. Zip Code 21562	)		nited St	•
	ns 23	Funeral	11. Marital Status 12. Was Decedent Ever	in U.S. 13. Was		panic Origin? (Specif Mexican, Puerto Ric			American Indian,
21215-0036	is should be filed within 72 hours after death with the Maryland in and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exercise must be nutified at	þ	1 ☐ Never Married 2 ☐ Married  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  Armed Forces?  1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			Mexican, Puerto Ric Specify:	an, etc.)	Black, Specify:	White, etc. White
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212	within jene. r than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		arian			Librar	У
pu	al Hygi d other vent,	BeC	17. Father's Name (First, Middle, Last)	•	1:	8. Mother's Name (F			
Maryland	should be filed wand Mental Hygies marked other tumatic event, In	ဥ	Jonas Fazenbaker			Flossie			
	f and 2 sho Health and I em 27 Is ma other trauma		19a. Informant's Name/Relationship (Type. Print) Patrick Laffey/ son	7509 Mag	cArthur	d Number or Rural R Blvd., Cal	bin Jol	nn MD, 2	0818-1802
altimore,	0 = = 0		MX Burial 2 Cromation 2 Demoval from State	20b. Place of Disposition cemetery, cremator St. Peters	ry or other place) Cemeter	<sup>2</sup>   2009			ity or Town, State ort Maryland
Ball	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee  F. Wagne Bril		ame and Address Church	<sup>of Facility</sup> Boal St, Weste		al Home , Maryla	and 21562
			23a. Part1. Enter the diseas, or complications that cause 1 the shock, or heart failure. List only one cause on each line.	death. Do not enter the	ne mode of dying,	such as cardiac or re	espiratory arre	est,	Approximate Interval Between Onset and Death
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_,	icate be executed physician and the burial-transit	Examiner	resulting in death) Last  C  Due to (or as a column as a	nsequence of):					
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O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☑ ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time of the past 12 mopths? 4 ☐ Pregnant at time of Unknown	Fetal death 3 Ect	topic pregnancy her <i>(specify)</i>			23d. Date Mont	
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ord	law requires that as been signed I 2 should be det						1 □ Ye	s 2 □ No 3	☐ Probably 4 ☐ Unknown
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Division	tal or Attress after de al Directo ed in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - building, etc. (S	At home, farm, street, f Specify)	factory, office	28f.	Location (Sti City or Town		or Rural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  1□ Certifying Physician: To the best of my 2□ Medical Examiner: On the basis of examiner and manner stated.	amination and/or investig	curred at the time igation, in my opir	, date and place, and nion, death occurred	d due to the ca at the time, da	ause(s) and man ate and place, an	ner as stated. d due to the cause(s)
	To t To tl	ž	29b. Signature and title of certifier		29c. License n				Month, Day, Year)
			Hellm	//h 05 \ /**	D26	907		Tury 28	2009
_		6	30. Name and address of person who completed cause of death Dr. Harjit Sidhu, 925 Bishop			and, Md.	21502		
	Sta Registr		31. Date filed (Month, Day, Year)  32. Begistrar's S  JUL 29 2009	Signature		, - 200			

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death . 2009 Physician July 26, Eric Lee Lisantti /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett County Memorial Hospital Oakalnd Garrett If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Days Hours 1 M 2 F 519-94-7021 48 May 27, 1961 Director Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at Director MD Garrett Oakland 10q. Citizen of What Country? 10e. Street and Number 10f Zip Code or Items 23a or 21550 302 N. 4th Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 ☑ No Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No <u>ک</u> If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Gerald Lisantti Beverly 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 N. 4th Street, Oakland, Maryland Susan K. Lisantti/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Important: If it any injury or o Department of 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State Country Side Crematory July 28, 2009 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. Signature of Funeral Service Licensee elimai 203 South Second St., Oakland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Immediate Caus (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed 24a. Was an

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🖳 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

3. Time of Death

8:25

Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 □ No

California

White

14. Race - American Indian,

Black, White, etc.

Specify.

State Registrar

Be

Certification: To

Medical

25. Was case referred to medical examiner?

5 Pending investigation

6 Could not be

Year)

1 Tes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

Director:

within 24 hours a To the Funeral C

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of Injury

(Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			For State	State	of Marylan		artmen rtificate		ealth and N	lental H		2 U	09	25152
			Registrar  1. Decedent's Name (First, Middle	o (ast)		Cei	uncau	e OI L	Jealii	2. Date of	Reg.	No.		3. Time of Death
П	Physici	an			1					Month		Day	Year	
-	/Medio		Maria Concep  4a. Facility Name (If not institution		oucks		4h City	Town or	Location of Death	July .		2009 4c. County	of Dooth	3:24 p.m <sup>™</sup>
	Examir	ier	22983 Butternu	_	idilibel)		,						_	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthdav)	Cali:		1a If Under 24 Hrs.	8. Date of (Month,	3irth	St. N		S place (State or Foreign
	Director		556-68-3947	1□M 2∏F	61	Yrs.	Months	Days	Hours Min.	(Month, 08/13	Day, Ye	ar)	Cot	intry) fornia
			Usual Residence of Decedent		01			1		00/13	11)-	+ /	Call	IUIIIIa
	arylan show		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	a-f.s	cto	Maryland St. Ma	ry's	Cali	fornia								1 ☐ Yes 2 📉 No
	or 28	Director	10e. Street and Number				10f. Zip	Code			10g.	Citizen of	What Cou	intry?
	th will		22983 Butternu	t Lane			206	10			1	Jnite	1 Sta	ites
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examinan he notified at	Funeral	11. Marital Status		cedent Ever in U.	.S. 13.	Was Deced	ent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or	_	14. Ra	ce - Amer	ican Indian,
9	after or ite	E	1 ☐ Never Married 2 📉 Marr	ried 1 Tes	2 📆 No		1 DXYes 2		Specify:	mican, etc.)			ck, White	, etc.
203	ours	d by	3 Widowed 4 Divorced	Year or			1 A 103 Z		, ,	ican		Specif	His	spanic
21215-0036	72 h 'natu	Completed	15. Deceden (Specify only higher	t's Education st grade completed	i)	I (Give	dent's Usua kind of wor	k done d	lurina most of work	ing	16b	. Kind of B	usiness/li	ndustry
2	ithin ne. han	E G	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT us	e retired,	)	Ü				
	led w lygie her t		45 5 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2		Homem	aker			(=:		m Hor		
anc	be fi	Be	17. Father's Name (First, Middle,	Last)					18. Mother's Name	e (FIRST, MICTO	ile, Maio	den Surnar	ne)	
ž	ould J Mei narke	은	Robert Padilla			T			<u>Abigail l</u>		***			
Maryland	12 st th and 7 is r traur	1 8	19a. Informant's Name/Relations	hip (Type. Print)			-		and Number or Run					ip Code)
	1 and Healt em 2	U_0	William Loucks 20a. Method of Disposition		20h F	22983			t Lane, (	Califo Date				
Ö	iges nt of l		1 Burial 2XXCremation	3 Removal from		cemetery, crei	natory or ot	her place	9)	Jate	200	. Location	· City or I	own, State
ţ	t. Pa rtmer rtant		4 ☐ Donation 5 ☐ Other (S		Bri	nsfiel	d-Ech	ols	Cre 07/29	9/2009	Ch	arlot	te_H	all, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Madical Evantic must be notified at once.		21. Signature of Funeral Service	11	3	22	2. Name an	d Addres	s of Facility Brin	nsfiel	d Fu	inera]	Ноп	ne, P.A.
	4-1-00		Kyle S. Simo				2,55,	LOTI	AMORA MOS	THE TIE	Juar	GLOWI	, MI	20000
			23a. Part 1. Enter the disease, or shock, or heart failure. List	only one cause on	caused the deat each line.	h. Do not ent	er the mode	e of dying	g, such as cardiac	or respirator	arrest,			Approximate Interval Between Onset and Death
4,	Physician		Immediate Cause (Final disease or condition resulting in death)	_ao	2ep5/	S								Onset and Beath
7.	/Medical Examiner		resulting in death)	Due to	o (or as a conseq	uence of):								
		<u>.</u>	Sequentially list conditions,	b	RSI	+								
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	o (or as a conseq	uence or):								
	and al-trar	хап	that initiated events resulting in death) Last	c	o (or as a conseq	uence of):								
60	icate be executed physician and the burial-transit	ם			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
68760,	ficate phys the	edical		d										
Box (	Physician: The law requires that the death certific this certificate has been signed by the attending trial director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna							23d Da	ite of deli	verv
ğ	death atte	ciar	in the past 12 months?		e birth 2 🗀 Feta egnant at time of o		Ectopic p		1				onth	Day Year
P.O.	at the deby the tached	ysi	1 □Yes 2 🔼 No 9 □ Unknown	9 ☐ Unl			20.101 (4							
	that hed b		Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	nderlyi <b>n</b> g ca	ause give	en in Part I.	23e. Di	d tobac	co use con	tribute to	the cause of death?
of Vital Records,	quires n sign ald be	d by								1 (	∃Yes	2. No	3□ Pro	obably 4 ☐ Unknown
00	w requir s been s should I	Completed								24a. W	as an	24h	Were aut	opsy findings available
Re	: The law cate has	ᇤ								au	topsy		prior to c death?	ompletion of cause of
ta	iclan: Th certificate ector, pag		25. Was case referred to medical							1 □ Ye	_	No	1 🗆 Yes	2 🗆 No
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	ding Phy h. After this funeral c	n: To	27. Manner of Death	28a. Dat	e of Injury	28b. Time o		8c. Injury Work		28d. Describ			(-1	erfy)
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/is	Atter r dea ector	ifica	3 ☐ Suicide 6 ☐ Could	inod   28e. Plac	ce of Injury - At he	l ome, farm, str	eet, factory,	office					ber or Ru	ral Route Number,
Ö	al or	Certification:	4 ☐ Homicide determ	buil	lding, etc. '(Spe <i>cit</i>	Y)				City or	rown, S	tate)		
	ospit hour unera ly fille		29a. Certifier 1 Certifyir	ng Physician: To the	he best of my kno	wledge, deat	n occurred	at the tin	ne, date and place,	and due to t	he caus	e(s) and m	anner as	stated.
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	one)		anner stated.	and/or in				eu at trie tiff				
	Vitt To I	Σ	29b. Signature and title of certified	r				License		~ /	29d.	Date signe	d (Month	, Day, Year)
	81~		10)2	22	2			40	05575	5 (	-	MC	110	07
	0/	1	30. Name and address of person	who completed ca	use of death (Item	n 23a) (Type,	Print)							
	٧		Jennifer Schmie	dt, D.O.	40900 1	Mercha	nts La	ane,	Suite 20	)5, Le	onar	dtown	, MD	20650
	Sta		31. Date filed (Month, Day, Year)	3 2009 32.	Pegistrar's Signa	ature	,	וווענ	30 2009	. 11				
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar 251 Certificate of Death Reg. No." 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 25° 6:15 pm 200°9′ **Physician** C. Moats Margaret /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington 12441 Gateway Ave Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of 8 inth (Month, Day, Year) | 2 - 1 4 - 1 9 1 9 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🖫 F 90 220-30-9198 Hagerstown Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location 10b. County Worle the Medical Examiner must be notified at 1 Yes 2 No MD Washington Hagerstown Director or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21740 U,S.A 12441 Gateway Ave or Iteme 23a death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, et Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.
ant: If item 27 le marked other than "natural", or Iter try or other traumatic event, the Madical Examinate. ☐Yes 2X☐No f Yes, Give white 1 Never Married 2 Marned 21215-0036 1 Yes 2 No Specify: Specify. 3 ₩ Widowed 4 Divorced Year or Dates: . 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Inspector 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) clothing mfg.co. Elementary/Secondary (0-12) College (1-4or 5+) 0 9th grade 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be E. Springer Samuel C.King Mary 2 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley Stotlemyer daughter 12443 Gateway Ave. Hagerstown MD 2 12443 Gateway Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) July Date 29, 20c. Location - City or Town, State 20a. Method of Disposition Hagerstown, MD Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Cem. permit. Page Department of Important: If any Injury or once. 2009 21. Signature of Funera Service License 22. Name and Address of Facility Donald Edwin Thompson Funeral Home. Inc P O.ROX 310 Clear Spring, MD 21722 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. shock Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 X No or Attending Physician: 25. Was case relerred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: death. 1 Yes 2 No investigation Director: 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) ģ within 24 hours after To the Funeral Direc 4 - Homicide filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number 00063233 7-27-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown MD 21742 580 Northern Ave Shahid Mahmood 31. Date filed (Month State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month\_ **Physician** 4:10PM 2009 July Charles Edward MCCARNEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 15 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 X M 2 🗆 F Director 93 1916 Pennsylvania 174-01-3979 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Examinate routilied at 1X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1118 Marshall Street Completed by Funeral 21740 USA death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or ite ury or other traumatic event, Its Medical Examinal. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Tool and Die Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Harry B. McCarney Vesper Bloom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Avalon Avenue, Hagerstown, Maryland 21740 Alice Manford - Daughter Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Rose Hill Cemetery 7/29/09 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Chalende 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 6 dural resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 → No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an certificate has b performe 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation To the Hospita ... within 24 hours after death. To the Funeral Director: After remainstely filled in by the fur 1 ☐ Natural 1 10, 2009 Na 1 □ Yes 2 🛂 🕶 2 Accident 3 🗆 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

SH-10+1

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records.

State Registrar

ical

31. Date filed (Month, Day, Year) JUL 28

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

. License number

archard

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of M	1aryland	l / Depa	artment	t of H	ealth a	and M	lental Hy	giene Reg. No.	009	251	55
	20 10	W.	Decedent's Name (First, Middle, La.	st)							2. Date of De	aath		3. Time of D	eath
	Physici /Medi		Wilson Curtis	Merrit							Month 7	Day 20			) м
	Examir	_	4a. Facility Name (If not institution, give	e street and number	r)		4b. City,	Town, or	Location of	of Death		4c.	County of Dea	ath	
			408 Market St	reet			Poc	omo]	k e			Wo	orce s	ter	
5	Funeral	7.54	5. Social Security Number 6. S	ex 7. A	lge (In yrs. la	st birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9. Bi	rthplace (State or I	Foreign
100	Director		214-32-2175	₩ 2□F	91	Yrs.	WIOTINIS	Days	110013	Will I.	2-28-			dleTre	<u> ≥ M</u> P
	pu &		Usual Residence of Decedent  10a. State 10b. County		100 City	Town or Lo	estica							10d. Inside City	Limita
	sho sho	5	147	<b>+</b>										XIX Yes 2	
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show to Madical Examinat har notified at	Funeral Director	MD Worces  10e. Street and Number	rer	Poce	omoke		0-1-				10a Citi	4 \All+ C		
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	lter d	ű,	Never Married 2 Marned	Armed Forces	5?	. 13.1	f Yes, spec	rfy Cubar	n, Mexicar	i, Puerto	ecify Yes or No Rican, etc.)	0-	Black, Wh		
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Ş	2 hou	ted	15. Decedent's Ed	ducation		16a. Deced	dent's Usua	I Occupa	ition			16b. Kir	nd of Busines:	s/Industry	
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumstic event, Ina Medical Examinarization to Indifice at		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailin	ng Address	(Street a	nd Numbe	or Rura	al Route Numb	er, City or	Town, State,	Zip Code)	
	1 and 2 Health tem 27 I		Sharon A. Pr	ess		408	Mark	et	Stre	et i	Pocomo	ke i	MD 218	351	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition  1 XBurial 2 Cremation 3 C	Domount from Stat	0.00	nce of Dispo	isition (Nam	ne of	e)	7-2	5-09	20c. Lo	cation - City o	r Town, State	
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le le			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	ed the death. line.	Do not ent	er the mode	e of dying	, such as	cardiac (	or respiratory a	arrest,		Approximate Interval Between	en
S.	Physician		Immediate Cause (Final disease or condition			000	26							Inset and De	ath
1	/Medical		resulting in death)	Due to (or a	is a conseque	ence of):	· >	_		Α .		1		1 2	14
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9	eath certific attending pi	Mec	IF FEMALE:												
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1☐Live birth	2 🗀 Fetal o	death 3	Ectopic pre					2	23d. Date of de Month	elivery Day Ye	ar
0	the a	sic	1 Yes 2 No	4∐Pregnant . 9∐Unknown	at time of dea	ath 5□	Other (spe	ecify)	· · · · · · · · · · · · · · · · · · ·				MICHAEL	Day 10	(A)
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ū	Jing F	0	27. Manner of €eath  Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury	occurred		
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<u>&gt;</u>	l or Attendation after death	E	4 Homicide determined	28e. Place of It	njury - At hon etc. <i>(Specify)</i>	ne, farm, str	eet, factory.	, office				(Street and wn, State)		Rural Route Numbe	∌r,
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Med	29b. Signature and (itle of certifier	and manner s	SIAIUU.			. License						nth, Day, Year)	
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Ŕ	A 3		address of person who	completed cause of	death (Item 3	23a) (Type,	Print)	SI	sel	5	uito 1	105	Bo	comelo .	Car
	Sta	te.	31. Date filed (Month, Day, Year)		trar's Signatu	ite .		71.7		•			1	1 710	57
	Regist	2780	JUL 24	2009 Den	wa	A. A	back							718	3/

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item Registrar #10e, 20b, per F. Home, 7/24/09 Certificate of Death BA WCHD Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 23 Day **Physician** 2009 Stanley Howard Mast 8:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5 Hemlock Lane Ocean Pines Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9/29/1931 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours Min 1 X M 2 □ F 77 Yrs. Washington DC 578-38-7786 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Exaculture traumatical and Director 1 ☐ Yes 2 TXNo MD Ocean Pines Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Hemlock Ct. 5 Hemlock Lane 21811 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No þ Specify Specify: white 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Department Manager Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar Philip Mast Grace Wonn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirl Mast / daughter 112 Robin Hood Trail, Ocean Pines, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/24/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UR **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner HM Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 □Yes 2 🖼 No 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown icate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) al or Attending Ples after death. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 23/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registr<u>ar</u>

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31. Date filed (Month, Day, Year)

ORIGINAL

314 Franklin

32. Registrar's Signature

Kider

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Sut 403 Berlin mo 2181

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** nne 1,2:26 PV QÚ 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital Baltimore City If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Sept. 14, 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Year) 1 M 2 F 213-54-8724 Yrs 53 Sept. **Director** 1955 D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 321 North Market Street 21701 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner X Never Married 2 Married Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify þ Specify: 3 Widowed 4 Divorced White 'natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4 or 5+) the Sales Clerk Sales traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd Mental I John P. Maher Joan Davitt 2 and Nis ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Emily M. Osetek / Sister 3057 Linksland Road, Mt. Pleasant, SC 29466 partment of Health cortant: If item 27 injury or other tr 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department Important: I any injury o 4 Donation 5 Other (Specify) Smithsburg Crematory 7/21/09 Smithsburg, Maryland 21. Signature of Puperal Service Lic ROBERT E. DAILEY & SON FUNERAL HOMES, 1201 NORTH MARKET STREET, FREDERICK, MD 21701 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus caused t Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the death certificate be executed attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 TEctopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown ate has been sig page 2 should b 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 2 No **Physiclan**: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No Other: 4 Nursing Home 1 Yes 2 ER/Outpatient 3 DOA မှ 5 Residence 6 Other (Specify) the funeral Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Time of ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director; After th 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident To the Hospital or Attel within 24 hours after dex To the Funeral Director completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. of Vital Records, Division

10

DHMH 17 Rev 1/2001

GABRIEL 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

BERI 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parks

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RES-ODE

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

29a. Certifier

(check only

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MARIE YOUNGER MABREY JULY 5:15 A M 2009 15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** OUEEN ANNE'S 705 4TH STREET CRUMPTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yo 5/8/1935 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Min 1 □ M 2 🛚 F Director 214-34-5893 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Yes 2 □ No Director CRUMPTON MD QUEEN ANNE'S 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21628 USA 705 4TH STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates 1 □Yes 2X No ģ Specify: WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 h (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE SALESPERSON 12 12 should be filed w h and Mental Hygie 7 is marked other tl or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any Injury or other traumatic ev MARY COLE ISAAC NEWTON YOUNGER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NELSON MABREY/ HUSBAND 705 4TH ST. PO BOX 328 CRUMPTON, MD 21628 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CRUMPTON CEMETERY 7/17/09 CRUMPTON, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Sul 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIOPULMONARY ARREST /Medical Due to (or as a consequence of) Examiner GASTRIC CARCINOMA Sequentially list conditions, if any, issuing to humanate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or ex-e-consequence of) and Due to (or as a consequence of) Box 68760. attending physician certificate be Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 1 Live birth 2 Fetal death 3 Ectopic pregnancy õ Month Day Year 5 Other (specify) o 9 Unknown 9 Unknown ٥ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 🖺 No 2 🗆 No e Hospital or Attending Physician: 124 hours after death.
e Funeral Director: After this certifical letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

within 2 the

ms

State Registrar 29b. Signature and title of certifier

MD, 223 HIGH CHESTERTOWN, MD 21620 ARRABAL STJOHN C. JR, 31. Date filed (Month, Da

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

29c. License number

02388-9

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Physician АМ 8:30 August Marsh Vivian J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Citizens Care and Rehab Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | January 13, 1914 9. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Country) New York 1 ☐ M 2**X** F 95 085-40-9483 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f show traumatic event, the Medical Examiner must be notified at 1XIYes 2 No Frederick Director Maryland Frederick 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ō 21702 1600 Rosemont Avenue United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? or items, 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after or artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or itel Injury or other traumatic event, the Medical Examinat 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Isabel Page Caryl Otis Marsh ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2116 Carroll Creek View Court, Frederick, Maryland 21702 Marylee Schumeyer / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. August 4, 2009 Smithsburg, Maryland Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, 21. Signature of Funeral Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 morths?
1 ☐ Yes 2 No 3 🗆 Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performe 1 □Yes 2 No 2 □ No 1 □ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day Year)

(Check only one)

29b. Signature and title of certifie

30. Name and address of person

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

T

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

		For State Registrar	State of	Marylan		artment of F		Mental Hyg	iene	09	25	60
		1. Decedent's Name (First, Middle, Las	t)					2. Date of Death	h Day	Year	3. Time of	Death
Physicia /Medic	_	Gerald	Lorne		]	Martin		July	2 <sup>9</sup> 2	009	7:15	P M
Examine		4a. Facility Name (If not institution, give	street and numb	per)		4b. City, Town, or	Location of Deat	h	4c. County	of Death		
<b>*</b>		14110 Zinnia Lane					stown		Was	hing		
Funeral Director		5. Social Security Number 6. Social Security Number 1215-36-6622	ex 7. M 2□F	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Coui	place (State on htry) yland	or Foreign
pu 🔉		Usual Residence of Decedent  10a, State 10b, County		10c City	y, Town or Lo	cation					0d. Inside C	ity Limits
faryla f sho	ō											2 <b>∑</b> No
the A	Funeral Director	MD Washing	con	H	agerst	OWN 10f. Zip Code		10	0g. Citizen of V	Vhat Cour	ntry?	
3a or	٥	14110 Zinnia Land	2			21742	)		II.	S.A.		
ms 2	ner	11. Marital Status	12. Was Decede		S. 13.	Was Decedent of H f Yes, specify Cuba		Specify Yes or No-	14. Rac	e - Americ	can Indian,	
after or ite		1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐Yes 2 IfYes, Give			ryes, specmy Cuba I∐Yes 21 <mark>∑</mark> No	Specify:	to rican, etc.)		k, White,	etc.	
hours af	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:					Specify	Wh	ite	
72 h "natu	Completed	15. Decedent's Ed (Specify only highest grad			(Give	dent's Usual Occup kind of work done	during most of wo		16b. Kind of Bu	usiness/In	dustry	
within ene.	d m	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT use retired Driver	1)		Feed a	and C		
Hygir Hygir		17. Father's Name (First, Middle, Last)			ILUCK	DIIVEL	18. Mother's Nar	me (First, Middle, N			ուրըւչ	
id be file lental H ked oth ic even	To Be	Kenneth Martin					Ada Esi	helman				
shou and N and N		19a. Informant's Name/Relationship (7	Type. Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Number,	City or Town,	State, Zip	Code)	
alth a		Joseph Martin/Son			1340	5 Wellsp	ring Dr.	Hagersto	wn, MD	217	40	
Ter Per Per Per Per Per Per Per Per Per P		20a. Method of Disposition	Damas of frame Ch	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other place	e)	Date 2	20c. Location -	City or To	wn, State	
Pag ment ant: I	-	1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		Res	t Have	n Cemete	ry 8/1/	2009	Hagers	town,	MD	
Destitiniore, Intervient Z 1 Z 13-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mertalla Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprimer must be notified at once.		21. Signature of Funeral Service Licen	see					est Haver			-	
0 0 7 0 0		J. Much Su	77					Ave., Hag	<u>,                                      </u>	n, MI		
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	one cause on eac	th line.		-			est,		Approximat Interval Bet Onset and	tween
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	11000	Min	Inf.	inch tio	н				
Examiner			Due to (or	as a consequ	uence of):					-		
	ē	Sequentially list conditions, cause. Enter Underlying	U.	D (ab.								
cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								Ì		
O, e exe an ar rrial-tr		resulting in death) Last	Due to (or	as a consequ	ence of):							
icate be executed physician and the burial-transit	dical		.d						-			
ertific ertific ting p e as t	Mec	IF FEMALE:	00 1/	-								
attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?		th 2 Feta	Ideath 3	Ectopic pregnanc	у			te of deliventh		Year
the de	Physician/Me	1 □Yes 2 □No 9 □ Unknown	9 ☐ Unknov	nt at time of d	leati 5L	Other (specify)						
that that detail		Part II. Other significant conditions of	ontributing to dea	th but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use conf	ribute to t	he cause of	death?
auires nu sign	p p	Renal	Fullery					1 □ Ye	s 2 No	3 ☐ Pro	bably 4□	Unknown
s bee	olete							24a. Was ar		Were auto	psy findings	available
The la	Completed by							autops perform 1 ☐ Yes 2	ned?	prior to co death? 1 □Yes	ompletion of o	ause of
lan: lan:	0	25. Was case referred to medical					26. Place of De	ath (Check only on		10103	2 1110	
hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 🔲 Inj	patient 2 🗆	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursing I	Home 5 Reside	ence 6 🗆 Oth	ner (Speci	fy)	
office of the control	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury Day, Year)	28b. Time of Injury	Worl	yat k? Yes 2∐No	28d. Describe ha	w injury occur	red		
r Atter rer dea rector rector	tifica	3 Suicide 6 Could not be determined	28e. Place of building	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, str	eet, factory, office		28f. Location (St. City or Town		er or Run	al Route Nun	nber,
urs af		TT/2										
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 CertifyIng Ph (Check only one) 2 Medical Exam	ysician: To the basiner: On the basiner	sis of examina	wledge, deat tion and/or in	n occurred at the til vestigation, in my c	me, date and place opinion, death occ	e, and due to the curred at the time, d	ause(s) and m ate and place,	anner as and due t	stated. o the cause(	3)
To the within To the comp	ž	29b. Signature and title of certifier		_		29c. Licens		2	9d. Date signe	d (Month,	Day, Year)	
		Willi	15/6			23	8471		7/31	109	7	
		30. Name and address of person who							1700			
		William B. Kerns 31. Date filed (Month, Day, Year)		11 Jef distrar's Signa		Blvd., S	smithsbul	rg, MD 2	1783			
Stat Registra		AUG 06	2000	insuas signa	A. x	partel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 300 q ar Day 13 James Warren Phelps 4:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Yoint 5. Social Security Number 1-teath Case System 109, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 14, 1942 Sex 1 X M 2 □ F Months Days Hours 212-42-0275 66 Oct. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2X No Baltimore Phoenix Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Sunnyview Drive 21131 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Myes 2 No If Yes, Give Year or Dates: 1965-69 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify: White 3 ☐ Widowed 4 【 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Sun Elementary/Secondary (0-12)
Twelve Years College (1-4or 5+) Baltimore, Maryland Linotype Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Adoram Phelps Doris Eva Mundey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Sunnyview Drive, Phoenix, Maryland Linda J. Brennan (niece) 20c. Location - City or Town, State West Chester, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R.A. Ferris & Co., Ind. 07/23/09 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, 21. Sign ure of Funeral Service License Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Obstructive Hymonery **UNKNOWN** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

P.O. Box 68760, Division of Vital Records,

Name Known To Mysician : Phelps, James Work

Baltimore, Maryland 21215-0036

burial-t attending physician for use as the buria death certificate be signed by the a cate has been si page 2 should b filled in by the funeral s after death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any injury or other traumatic event, Ite Magnones.

**Physician** 

/Medical

**Examiner** 

2

Completed

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Examiner

Physician/Medical

Completed

Be

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Certification:

Medical

death with the Maryland

Attending Physician: ō e Hospital o 24 hours af e Funeral Di To the Vithin 2

IVA

State Registrar

29b. Signature and title of certifier

29c. License number

tealth Care System:

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. YA Marker

and manner stated.

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Physician July 24, 8:52 P M Doris Alene Payne /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ST. Mary's Charlotte Hall 30422 Comanche Lane 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 👽 F 218-30-0176 75 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Pages 1 and 2 should be filed within 72 hours after death with the Marylament of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-4 shov ury or other traumatic event, It a Medical Examination and the modified. 1 □Yes 2 No Director Maryland ST. Mary's Charlotte Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 30422 Comanche Lane 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 TNo White If Yes, Give Year or Dates: þ Specify. 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker Elementary/Secondary (0-12) College (1-4or 5+) At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Noah John Logsdon Laura Virginia Wiles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonnie Tabick/Daughter 14675 Evening Star Ct., Hughesville, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Ju1<sup>⊕ate</sup>30, permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem, 2009 Cheltenha, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Prinsfield-Echols F.H., P.A., 21. Signature of Funeral Service License M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician disease or condition resulting in death) C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nunseourings of). Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 0 0 1 ☐Yes 2 ☐No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be `2 🗖 Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JUL 28 2009

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Berube, Mechanicsville, MD 20659 Registrar's Signatur

29c. License number

00000506

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Martin **Physician** Edward Ryan 2009 7:15 a M 22, July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 712 Horton Drive Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 **3**M 2 □ F New York Aug. 13, 1925 Director 126-16-1939 Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10b. County 10c. City. Town or Location th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, it a Medical Exact mental by mailing 1 ∏Yes 2X No Director Maryland Montgomery Silver Spring the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20902 USA 712 Horton Drive death \ Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If them 27 is marked other there any injury or other traumout 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Affiled Follows. 1 [25]Yes 2 ☐ No If Yes, Give Year or Dates WWII 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 XNo Specify þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Security Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeremiah Edward Ryan Isabella McGee ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Winifred Ryan/Wife 712 Horton Drive, Silver Spring, MD 20902 July 27, 2009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State National Veterans 4 ☐ Donation 5 ☐ Other (Specify) Calverton, New York 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Heart Disease years /Medical Due to (or as a consequence of): years Examiner Atherosclerosis Sequentially list conditions, and a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) vears Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Diabetes Mellitus Due to (or as a consequence of) P.O. Box 68760, Physician/Medical vears Severe Left Ventricular Systolic Dysfunction 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) I ☐Yes 2 ☐ No 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Chronic Obstructive Lung Disease, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Ischemic Cardiomyopathy, Aortic Stenosis 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 🔼 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2009 MO 11 1001/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10313 Georgia Avenue, Silver Spring, MD 20902 Herman B. Segal, MD 31. Date filed (Month, Day, Year) Registrar's Signatu State 23 JUL 2009

DHMH 17 Rev 1/2001

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2009 Month July Lawrence Edward Richardson 27, 6:35 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 24,1916 9. Birthplace (State or Foreign 1 M 2 □ F Months Days Hours Washington, DC 93 577-10-4549 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location Charles La Plata 1 □ Yes 2 X No Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20646 IISA 12730 Amberleigh Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Specify: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Contract Specialist Food and Drug Elementary/Secondary (0-12) College (1-4or 5+) Administration 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth L. Evans Thomas Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Claudia Sansbury/Daughter 12730 Amberleigh Lane, La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) Julay: 31, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bufflal 2 ☐ Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 2009 Charlotte Hall,MD 5 □ Other (Specify) 4 Donation 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., er IS 21. Si mature 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 23a. Pay 1. Enter the disease, or compi shock, or heart failure. List only or Approximate Interval Between Onset and Death sations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Immediate Cause (Final ARRHYTHMIA ARDIAC disease or condition resulting in death) Due to (or as a consequence of): SSENTIAL PERTENSION Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 110 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred

physician and s the burial-transit Physician/Medical attending p for use as t ed by the a \$

Hospital or Attending Physlcian; The law requires that the death certificate be executed

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Division of Vital Records, P.O. Box 68760

Examine

Completed

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Medical Certification: To

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

**Examiner** 

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

29c. License number D67788 29d. Date signed (Month, Day, Year)

28,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MD

LEENA RAO KODALI 31. Date filed (Month,

State Registrar

32. Resistrar's Signature

State of Maryland	ick indenbie ink.	LIISUIC AII	Oopies	AIC L	-91
State of Manyland	/ Department of H	aalth and Ma	ntal Hye	viono.	U

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Betty 3:25 p Ross Lou Ju<sub>1</sub>y 27, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's 39146 Middleton Lane Clements 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Director 07/10/1933 Pennsylvania 165-26-7469 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a hour item. Director 1 ☐ Yes 2 No Maryland St. Mary's Clements 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 39146 Middleton Lane United States Funeral 20624 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🕱 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Jake Stevens Martha Lucille Gold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammie Guy/Daughter P.O. Box 166, Morganza, MD 20660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 07/31/2009 | Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons 22955 Hollywood Rd., Leonardtown, MD 20650 M01206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death End Stage Immediate Cause (Final COPD Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the criping Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 2 been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician: The certificate Division of Vital 1 ☐ Yes 2 ☐ No 1∐Yes 2∭MNo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after ( 4 ☐ Homicide filled in I 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the i 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) anounder 000 31344 N.K.Ja 07/28/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.K. Jayarawan 28227 Tuke Notch Rd. Mechanicsville MD MI 2065 32. Registrar's Signature 31. Date filed (Month, Day, Year) parker JUL 3 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ( 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician**  $P_{\mathsf{M}}$ 2009 11:20 July 31, Katherine Rosberry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Adamstown
If Under 1 Year | If Under 24 Hrs. Buckingham's Choice Health Care Center Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 🗓 F 90 Dec. 16, 1918 Massachusetts Director 136-18-7804 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location be filed within 72 hours after death with the Marylan tital Hygiene. sd other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Adamstown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 3200 Baker Circle. 21710 Funeral #H-027 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 □Yes 2X No Specify 2 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 4 Homemaker s 1 and 2 should be filed wi f Health and Mental Hygier Item 27 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Effie MacLeod Robert MacDonald ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau 11429 Beechgrove Lane, Potomac, Maryland 20854 Rick Rosberry / Son 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 108/05/2009 Smithsburg, Maryland 4 □ Donation 5 □ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service Licensee Keeney and Bastord PA Funeral Home MO1473 106 E. Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2VZ No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only and manner stated. 29d. Date signed (Manth, Day, Year) 29b. Signature and title of certifier 29c. License number

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Saltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

DAVE

5200 BAKE 32. registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

factor

AD AMS TOWN

ORIGINAL

09-05500 Jose M. Rodriquez

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jose M. Rodrique		- For State	St	ate of Maryl		partment of <i>ertificate of</i>			Menta	al Hyg		j. <b>N</b> o.	211	19 2516
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Ī	21. Signature of Fu	ineral Servic	e Licensee		22 F E	Name and LLOW	Address HI	of Facility ELFEN	BEIN	& NEW	NAM F	UNERAI	HOME
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Division of Vital Records, P.O. Box 68766 Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicily filled in by the funeral director, page 2 should be detached for use as the b	Phy	Part II. Other sign	nificant cond	litions contributin		not resulting in the	underlyin	g cause g	given in Pa	art I.	23e. Did t	obacco use	e contribute	to the cause of death?
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	Physici /Medio		Decedent's Name (First, Middle, Last)     Carrie Jean Roberson		2. Date of Deat July 21		3. Time of Death 10:24 a M			
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Ī	Funeral Director		5. Social Security Number 577-62-0340 6. Sex 1 Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11-11-1	9. B 944 Al	irthplace (State or Foreign Country) a bama			
	land ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
	e Mary	ctor	MD PG Capitol Heights				M∏Yes 2□No			
	with the	I Dire	10e. Street and Number 1120 Elfin Ave. 10f. Zip Code 207	43	1	0g. Citizen of What 0	Country?			
တ	flied within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Modeal Expulser matter rollind at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Mar		pecify Yes or No- Rican, etc.)	Black, Wh				
003	ural", o	d by	3 ☐ Widowed 4 ☐ Yourced If Yes, Give Year or Dates:			Specifila				
21215-0036	ithin 72 h ne. <b>nan "natı</b> M	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	pation during most of work d)	king	16b. Kind of Busines				
22	iled w Hygier ther th		12 Dietician  17. Father's Name (First, Middle, Last)	18. Mother's Nam			beth's Hospita			
Jan	should be fi and Mental H s marked of sumatic ever	To Be	Alexander Mitchell	Lorease	Brag	•				
⋝	and 2 shore ealth and Nort		19a. Informant's Name/Relationship (Type. Print)  Sherry Allen/ Daughter  19b. Mailing Address (Stree 1120 Elfin Av							
more	Pages 1 nent of H int; If itel iry or oth		20a. Method of Disposition  1 \( \overline{\text{Meurial 2}} \subseteq \text{Cremation 3} \subseteq \text{Removal from State} \)  4 \( \subseteq \text{Donation 5} \subseteq \text{Other (Specify)} \)  20b. Place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory or other place) and the place of Disposition (Name of cemetery, crematory) and the place of Disposition (Name of cemetery, crematory) and the place of Disposition (Name of cemetery, crematory) are placed or other plac	em. 7-31	-09	20c. Location - City of Clinton,				
Balt	permit. Departr Importa any init		21. In nature of Funeral Service Licensee 22. Name and Addr 10583 Mid			or II FH Plains,	MD 20695			
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a Cardiopulmonary Arrest	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death			
	/Medical Examiner		Due to (or as a consequence of):			3-6months				
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate accordance or injury)				3-6months			
	ecuted and transit	Examiner	that initiated events							
2/60,	ate be executed hysician and the burial-transit	ical	Due to (or as a consequence of):  d.							
P.O. Box 68	The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnan at time of death 5 □ Other (specify) □ Unknown	су		23d. Date of o	delivery Day Year			
ν. 7.	s that ined by e deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?			
	w requires that s been signed I should be det		Coronary Artery Disease		1 🗆 Ye	es 2□No 3□	Probably 4 Unknown			
I Kecords,	r <b>sician</b> : The law r s certificate has be lirector, page 2 sh	Completed	Diabetes Mellitus		24a. Was a autops perfor 1 □Yes	an 24b. Were sy prior t med? death 2 ☑No 1 □Y	autopsy findings available to completion of cause of ? es 2 🛣No			
VITA V	certific ector,	æ	25. Was case referred to medical examiner?  Hospital: Ast,	26. Place of Dear	th (Check only or	ne)				
Ö	ding Phys h. After this funeral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Inju	4 LI Nursing H		ence 6 ☐ Other (S ow injury occurred	pecify)			
Division of Vital	E # 12 B	Certification:		rk? ]Yes 2∐No	28f. Location (S City or Tow.		Rural Route Number,			
ַ בֿ	To the Hospital or Atter within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifler  (Check only  2 Medical Examiner: On the basis of examination and/or investigation, in my	time, date and place	, and due to the	cause(s) and manner	r as stated. due to the cause(s)			
,	ithin 24 the F the F omplete	Medical	one) and manner stated.	se number		29d. Date signed (Mo				
	F > F o		$\Delta$ $\Delta$ $\Delta$ $\Delta$ $\Delta$ $\Delta$ $\Delta$ $\Delta$ $\Delta$ $\Delta$			July 21,				

State

State 31. Date filed (Month, Day, Year)
Registrar

7100 Baltimore Ave. #509 College Park, MD 20760

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Arvind Mehta 7100 Baltimore Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ringgold Jr. Month Roger R. **Physician** 10:25PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** albot Memorial If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 ★M 2 ☐ F 90 Director Sept. 5, 1918 217-03-2207 Maryland Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Examiner must be rediffed at once. 1 Yes 2 No Director Maryland Caroline Ridgely 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 107 Maryland Avenue 21660 United States of America Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 No 1940— If Yes, Give Year or Dates: 1945 Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Kinggold, Pager Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify Specify: Caucasian ģ 3 XWidowed 4 ☐ Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Salesman Automobile HS Grad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roger Rochester Ringgold, Sr. ٩ Helen Madara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 444, Ridgely, Maryland 21660 Roger R. Ringgold, III Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 7/31/2009 Greensboro, Maryland 21. Signature of Juneral Syrvi 22, Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 audo LOCK 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** accident Cereprovocula da disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical attending p nse IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) signed by the a d be detached for P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Charne 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed Physician: The 2 🗆 No Vital 1 TYes 1 ☐ Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ð this After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 4 31. Date filed (Month, Day, Year) Redistrar's Signature State Registrar

			1 - State of Maryland / [ Registrar		rtment of Health a tificate of Death			ene . No. 2 () () 9	25170
	Physici	an	Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death 2:50 aM
	/Medic	al	William Albert Sharon  4a. Facility Name (If not institution, give street and number)	Т	4b. City, Town, or Location		uly 2	6 2009 4c, County of Death	
	Examin	er	NMS Health Center		Hagerstow			Washing	
	Funeral Director		5. Social Security Number 219-20-0440 6. Sex 1 M 2 F 8 2	rthday)_ Yrs.	If Under 1 Year If Under Months Days Hours	24 Hrs. 8. I	Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign ntry) ntry) ntry) ntry)
7	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow	n or Loc	ation				10d. Inside City Limits
	Maryla -f sho iled at	tor	MD Washington Hage	rst	own				1 ☐ Yes X☐ No
	th the or 28a s notif	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	ntry?
	ath will	ral	14014 Marsh Pike		21740			U.S.A	
220	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  14. Was Decedent Ever in U.S. Armed Forces?  15. Was Decedent Ever in U.S. Armed Forces?  16. Was Decedent Ever in U.S. Armed Forces?		/as Decedent of Hispanic Or Yes, specify Cuban, Mexica ☐ Yes 2【【No Specify:		Yes or No- an, etc.)	14. Race - Ameri Black, White Specify: W	
5	72 hor	eted	15. Decedent's Education 16a (Specify only highest grade completed)	. Deced	ent's Usual Occupation ind of work done during mos O NOT use retired)	st of working	9.5	b. Kind of Business/I	•
7	vithin and the substitution of the substitutio	Completed			o NOT use retired) der/ Labore		1	Flooring	Company
7	2 should be filed withi and Mental Hygiene. is marked other thar aumatic event, the M		17. Father's Name (First, Middle, Last)		18. Moth	er's Name (Fi	rst, Middle, Ma	iden Surname)	
<u>0</u>	should be and Mental marked c	To Be	Charles H. Sharon		Cl	ara P	atton		
, Mai	1 and 2 sho Health and N em 27 is ma other trauma		Gladys Whipp sister	19	Address (Street and Numb W.Church St	. Wil			, , , , , , , , , , , , , , , , , , , ,
20	permit. Pages 1 Department of He Important: If iten any injury or oth		20a. Method of Disposition  1 □ Burial 2 ▼Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)		urg Cremato		20	oc. Location - City or T Smithsbur	
Dall	permit. Depart Import any inj		21. Signature of Funeral Service Licensee  21. Signature of Funeral Service Licensee  23. Part1. Enter the disease, or complications that caused the death. Do	Do	Name and Address of Facilionald Edwin O BOX 310	ı Thom	pson E Sprir	Funeral H	Iome,Inc
ji,	Physician /Medical Examiner	niner	shock, or beart failure. List only one cause of acach line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence consequence consequence)  Due to (or as a consequence consequence)	05+ of):	ructive Pu	_			Approximate Interval Between Onset and Death
6,00,	icate be executed physician and s the burial-transit	edical Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence d.	of):					
O. DOX OC	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of deliment	very Day Year
Colds, T	quires that in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting i	in the un	derlying cause given in Part	l.		cco use contribute to	
חשב ו	The law re ate has bee page 2 sho	Completed					24a. Was an autopsy performe	prior to c	copsy findings available completion of cause of 2 No
V II.o	sician: certific rector,	Be	25. Was case referred to medical examiner?  Hospital:		Othor		heck only one)		
	ding Phys h. : After this funeral di	tion: To	27. Manner of De th 28a. Date of Injury 28b.	Time of Injury	3 DOA Other. 4 DON  28c. Injury at Work?  M 1 Yes 2	28d		ce 6 ☐Other (Spec rinjury occurred	ify)
	al or Atten after deat I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fe building, etc. (Specify)	arm, stre	et, factory, office	28f.	Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	ne Hospits 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledg 2 Medical Examiner: On the basis of examination and manner stated.	je, death ind/or inv	occurred at the time, date a restigation, in my opinion, de	and place, and eath occurred	due to the cau at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To th To th Comp	Me	29b. Signature and title of certifier		29c. License number	2 -		d. Date signed (Month	
)					0523	13		07-27-	2007
4	4-2		30. Name and address of person who completed cause of death (Item 23a)  Khalid Waseem 1126 Opal Co				21710		
1	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	urt	Hagerstown	n, MD	21742		
	Registi		JUL 28 2009	1	all				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 23<sup>Day</sup> July 2009 Physician 1:25 P M Richard Carson Shain /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Maugansville 13920 Maugansville Rd. If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** XXM 2□F Yrs 215-42-3275 Jan. 1946 Maryland 63 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantine must be notified at 10a State 1 □Yes XXNo Director <u>Maryla</u>nd Maugansville Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21767 13920 Maugansville Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1965— If Yes, Give Year or Dates: 1967 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced 1967 White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumbing Estimator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eichelberger Doris June Edward Shain ပ James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13920 Maugansville Rd. Maugansville, MD <u> Mary Shain</u> - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Toth State 1 ☐ Burial → Tax remation Smithsburg Crematory July 25,2009 Smithsburg, Maryland 4 Donation 5 Dother (Special re of Fun ral 5000 Osborne Aftenerally Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. the ! attending pt nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed Hospital or Attending Physician: The certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☑No Division of Vital After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. within 24 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Compos

State

Michael MCO 31. Date filed (Month, Day, Year) JUL 28 2009

32. Registrar's Signature

Registrar

09-05786 Henry Steyer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ July 24, 2009 1020 hrs Medical Examiner Leith Steyer Henry 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Oakland Garrett 1251 Bethlehem Road ff Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Country) MD Director 1X M 2 49 Yrs Jan. 213-78-6565 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No "natural", or items 23a or 28a-f show Examiner must be notified at once. 0akland MD Garrett Director 10g. Citizen of What Country' 10f. Zip Code 10e. Street and Number 21550 United States 1251 Bethlehem Road 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' 1 Never Married 2 2 X No Yes Specify: White Yes 2 X No specify: Yes, Give Year Widowed 4 X Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 hours Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Medical nt of Health and Mental Hygiene. t: If item 27 is marked other than other traumatic event, the Medical 21215-0036 Construction Carpenter 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Myrtle Marie Ganer æ Keith Willard Steyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Baltimore, MD 5355 Gorman Road, Oakland, MD Wanda Steyer, Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Department o 7/29/2009 Cumberland, MD Cumberland Crematory Donation 5 Other Specify: or 22 Name and Address of Facility David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD 21. Signature of Funeral Service Licensee 1 the Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Ungenving Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed 23a,27,perME, g894 8/19/09 Physician/Medical AMENDED attending physician or use as the burial X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 9 Unknown ed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o. Yes 2 ✔ No 3 Probably 4 \$ Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy s certificate has b rector, page 2 sh death? performed? ✔ Yes 2 1 V Yes 2 26.Place of Death (Check only one) Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: Residence 6 🗸 Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Hospital or Attending 24 hours after death. Certification: 1 X Natural Yes 2 Director: Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) within 24 hours a determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number July 25, 2009 O.C.M.E. mel 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 31. Date filed (Montiful, Y31) 32. Re State Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 7:40  $A^{M}$ July 27, 2009 Robert Franklin Shaffer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Garrett McHenry 110 Laurel Ridge Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1**™** M 2□ F West Virginia 27, 1959 49 Dec. 232-06-8979 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 X No McHenry MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21541 110 Laurel Ridge Rd. 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2**X** No Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Garrett County Board (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) of Education School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Ann Lambert Rov Robert Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 110 Laurel Ridge Rd, McHenry, MD Elizabeth L. Shaffer/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Country Side Crematory July 28, 2009 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 0 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Smal ears Due to (or as a consequence of): and pancrea Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Lectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 ANo 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28b. Time of

the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Box 68760, attending physician for use as the buria P.0. certificate has been signed by the rector, page 2 should be detached Division of Vital Records, director, this After thi funeral of

death.

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within 24 hours a

To the Funeral

completely

**Physician** 

/Medical

**Examiner** 

Funeral Director

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Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

of 2 should be filed within 72 hours after death with the Marylan Ith and Mental Hygiene. 
77 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Eventher must be notified at

1 and 2 s Health a sem 27 is

permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr.

Physician

/Medical

Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D64302

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number 07-27-09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

255 N Fourth Street Suite / Oakland MO 21550

State Registrar 31. Date filed (Month, Day, Year) **NIL 30** 

Buckingham

	•	For State Registrar	State of M	aryland		rtment tificate			Mental	Hygie Reg	601	9	25171
		1. Decedent's Name (First, Middle, Last)							2. Date Mont	of Death	Day	Year	3. Time of Death
Physici /Medio		Thelma Marie Stro	ad						July	27,			10:15 A
Examin		4a. Facility Name (If not institution, give s Devlin Manor Nursin				Cum	oerla				4c. County	gany	
Funeral Director		190-20-1495	M 2 <b>∑</b> F 7. Ag	де (In yrs. Ia 75	* '	If Under Months	Days	If Under 24 Hrs Hours Min	Jan.	of Birth th, Day, Y	1934	Cou	place (State or Forei intry) insylvania
8a-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  MD Allegany			Town or Local	nd				100	. Citizen of		10d. Inside City Limi 1 \( \overline{\text{Y}} \) Yes 2 \( \overline{\text{T}} \) into 2
ben 2	Dir	10e. Street and Number				10f. Zip					USA	what Cot	antry?
and Mental Hygiene. Is marked other then "natural", or Iteme 23s or 28s-1 show aumstic event, the Medical Examinar must be notified at	y Funeral	1 Never Married 2 Married	2. Was Decedent Armed Forces' 1 ☐ Yes 2 🙀 If Yes. Give	?	t	Vas Deced	ent of His ify Cubar	spanic Origin? ( , Mexican, Pue Specify:	Specify Yes rto Rican, et	or No-	14. Rac	ck, White	
Ingo within 72 hours are obsain with the way said Hygiene. Sther then "natural", or Itema 23a or 28a-1 show ent, the Medical Examinar must be notified at	Completed by	3 Widowed 4 Moivorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		5+)		kind of wor OO NOT us	l Occupa k done di e retired)	tion uring most of w	orking		Sb. Kind of B	lusiness/l	hite ndustry
/gien	Con	10			Homer	naker					Own Ho		
0 =	To Be	17. Father's Name (First, Middle, Last)  Earnest Hutzel						18. Mother's Na			viden Sumar	me)	
and !		19a. Informant's Name/Relationship (Type				•		nd Number or F					
n 27		Lois J. Rounds/Sist	er					l Pike,		_			1536
Department of Health and Menia Important: If Item 27 is marked eny injury or other traumatic evonce.		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	Ce	ace of Dispo metery, cren Lawn	natory or of	ther place	dens Ju	Date ly 29,		oc. Location  9 LaVa	-	Maryland
Departr Imports eny inje		21. Signature of Furthal Service License	maw		1.0			s of Facility No.				omes, 1536	P.A.
octor: After this certificate has been signed by the attending physician and more positive this certificate has been signed by the attending physician and positive the funeral director, page 2 should be detached for use as the burial-transit of page 2.	edical Examiner	Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, and leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a:	s a consa u	ence of):	A , .	en	bolee					7 day
by the attending phitached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. tf yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp				_		ate of deli	ivery Day Year
signed by	ξ	Part II. Other significant conditions cor	tributing to death		iting in the u	nderlying c	ause give	on in Part I.	23e		icco use cor : 2 □ No		the cause of death
is certificete has been si director, page 2 should	Completed									. Was an autopsy perform	ed?	prior to death?	topsy findings avail completion of cause 2□ No
certificate rector, pag	Be	25. Was case referred to medical examiner?	itat				100	26. Ptace of D					
h. After this c funeral dire	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospitat: 1 ☐ Inpat 28a. Date of tn (Month, D	jury	ER/Outpatier 28b. Time of Injury		8c. Injury Work	46 140131119			ice 6 ⊟Ot v intury occu		cify)
E 5 E	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of to	njury - At ho etc. <i>(Specil</i> y		reet, factory	, office		28f. Loca City	ation (Stre or Town,	eet and Num State)	nber or Ru	ural Route Number,
within 24 hours after for the Funeral Dir completely filled in	Medical (	23a Conflier 1 Contrying Physical Check only one) 2 Medical Examin		of examinat									
withir To th	M	29b. Signature and title of certifier	7 , /					number		29			h, Day, Year)
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	1	30. Name and address of person who co	mpleted cause of				126	1218	ng	21	502		
St. Regist	ate rar	31. Date filed (Month, Day, Year)		trar's Signa	ture								

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×		Decedent's Name (First, Middle, Last	st)							2. Date of Month	Death	Day	Year	3. Time of	Death	
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pu »		Usual Residence of Decedent  10a. State 10b. County		10c Cib	v. Town or Lo	noation								10d. Inside C	ity Limits	
faryla fehov	o														2 🗆 No	
the A	rect	MD Garrett  10e. Street and Number		Frie	endsvi.							. Citizen of V	Vhat Cou	untry?		
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Mar 12 sh h and 7 is m		19a. Informant's Name/Relationship (				•						City or Town, State, Zip Code)				
C = 0 L	13	Joseph E. Sessa/S	on	20b. P	Place of Disp	osition (Na	me of			dsville, MD 21531 Date 20c. Location - City or Town, St				Town, State		
MOT Pages ant of nt: If it		1 🔀 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		tate	emetery, cre • Carm			1	[11] 12	30. 3	one	Hilla	ido.	TT.		
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Vision Attending r death. ector: Atte	atio	2 Accident investigation	27. Manner of Death   Natural   5 Pending   2 Accident   Accident   28a. Date of Injury (Month, Day Year)					Vork? ☐Yes 2☐No								
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Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		200 Contilion	husinian. T. c.	loant of my be-	and a district of the	(P. Denisor	E AL PERSON	or dates	dulan	and hear	the or	ea(e) and m	anner ac	etated		
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F 5 F 0	_	<b>)</b> / X	1/ /			_	D-23979					July 25, 2009				
	7	30. Name and address of person was	completed cause	of death (Iter	m 23a) (Type	e, Print)	2 20				Carlo Co					
	VP	Robert Goralski,				land,	Mary	land	21	550						
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State of Maryland / Department of Health and Mental Hygiene

						Certifica	te of	Death		Reg. No.	05 20110			
			1. Decedent's Name (First, Middle, Last)							eath Day	3. Time of Death			
	Physici /Medic	A VITE NO SILVER							July	•	09 0225			
5.	Examin		4a. Facility Name (If not institution, give	4b. City, Town, or	Location of Deat	h 4c. County	of Death							
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	P ,		Usual Residence of Decedent	10- 6	<b>T</b>						10d. Inside City Limits			
	aryla shov	_	10a. State 10b. County	100. 0	aty, rowr	or Location					1 ☐ Yes 2 ☑ No			
	8e-f	Sch	Maryland St. Mary	s				ardtown						
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	23e	Funeral	22680 Cedar Lane Ct					0650			USA			
	er m	ne	11. Marital Status	12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hisp. If Yes, specify Cuban,			Hispanic Origin? (S an, <b>Me</b> xican, Puer	Specify Yes or No to Rican, etc.)	o- 14. Rac Blac	e - American Indian, ck, White, etc.				
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Maryland 21215-0020	urai',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						16b. Kind of Business/Industry				
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	1 and dealth sm 27 ther t		John William Quade, J 20a. Method of Disposition		Place of	P.O. Box Disposition (N		Leonardto	Date		City or Town, State			
altimore,	Pages nent of H int: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ F			y, crematory of		ice)	July 28,					
	t. Pa tmen tant: jury	3	4 ☐ Donation 5 ☐ Other (Specify)	_	Charl	es Memori			2009	Leonard	dtown, Maryland			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mantal Hygiens. Department of Health and Mantal Hygiens than "netural", or items 23e or 28e-f show important: if item 27 is marked other than "netural", or items 23e or 28e-f show any Injury or other traumatic event, the Medical Evantine must be notified at once.		21. Sign-ture of Funeral Service Licens	60.				ess of Facility ey-Gardine:	r Funeral	Home, P.A				
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ita	icien: The certificate rector, pag	Bec	25. Was case referred to medical					26. Place of De	ath (Check only	one)				
<b>&gt;</b>	Attending Physicien: or death. ector: After this certific by the funeral director.	2	examiner? 1 ☐ Yes 2 <b>②</b> No	Hospital: 1 ☐ Inpatient 2	□ ER/Ou	tpatient 3 1	OOA Ot	her: 4 Nursing I	Home 5 ☐ Res	idence 6 □Oth	ner (Specify)			
0	g Ph erth neral		27. Manner of Death	28a. Date of Injury (Month, Day Year)		ime of	28c. Inju Wo	ry at	28d. Describe	red				
<u>ō</u>	ath. r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	"	M	1	Yes 2 □ No						
<u>s</u>	Atte er de ecto by th	)   	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
5	safter safter of Direct	Certification:		building, etc. (open	,				,					
	To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	siclan: To the best of my kr ner: On the basis of examin	nowledge	, death occurre	d at the ti	ime, date and place	e, and due to the	cause(s) and ma	anner as stated.			
	he H in 24 he Fi plete	edical	one)	and manner stated.	andi all									
29b. Signature and title of certifier  Aleccercify  29c. License number  46046  7									_	d (Month, Day, Year)				
								(-2	5-2009					
•		Ì	30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (	Type, Print)								
			A. N. ALIKHANI,	РО ВОХ 1819			MD 20	0740						
	Sta	te	31. Date filed (Month, July Yea? 7	2009 32. Registrar's Sig	nature	1.	10	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 18 Pay Month 1:09 P M July 2009 FACCIANI SIDERIS ELIZABETH 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 6/26/1938 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. 175-30-4263 1 □ M **2CX** 71 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 □ No MD Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 21702 1013 Bexhill Dr. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2**X** No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office manager medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Inez Dalle Valle Ralph Facciani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1013\ Bexhill\ Dr.,\ Frederick,\ MD\ 21702$ 19a. Informant's Name/Relationship (Type. Print) George Sideris (Husband) 20b. Place of Disposition (Name of Commentary, crematory or other place)

Smithsburg Crematory 7/19/2009 Smithsburg, MD 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial /2 ☑ Cremat/ 4 ☐ Donation 5 ☐ Other 3 Removal from State 5 Oth ecify) Sig atur o Fune Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 Part 1. Enter the disease, or com-shock, or heart failure. List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failu Immediate Gause (Final disease or condition resulting in death) Shock Due to (or as a consequence of): edema Sequentially list conditions, if any, leading to immediate cause. Enter the denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 27 No
9 Unknown 3 Ectopic pregnancy Day 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

þ

Completed

Be

2

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Macinal Examination in the profilled at

Baltimore, Maryland 21215-0036

burial-transil and physician the burial attending p signed by the a t be detached for signed by has

Physician/Medical

Completed

Be

၉

Certification:

Medical

P.O. Box 68760

Division of Vital Records,

certificate

the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

NAU MYNG

27. Manner of Death 1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

29b. Signature and title of certifier

28a. Date of Injury

(Month, Day, Year)

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (I HEE 32. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) State JUL 2 2 2009 Registrar

Registrar
DHMH 17 Rev 1/2001

State

2000

Maryland 21215-0036

Baltimore,

Box 68760,

P.0.

Division of Vital Records,

TERN SHURE DR.

ed cause of death (Item 23a) (Type, Print)

			1 - Far State Registrar	State of M	laryland		rtmen tificat			ind M	ental Hy	/giene Reg. No.	009	251	79
	1. Decedent's Name (First, Middle, Last)  Physician  /Medical  MYRTLE REGINA SWANN  2. Date of Death  JULY 30, 2009							09 <sup>Year</sup>	3. Time of D						
Exami			4a. Fecility Name (If not institution, gire CHARLES CO.N	UR.& REH	AB CI		4b. City,	LA	Location of PLA	ATA	0. Data -4.D	СНА	unty of Death		
	Funeral Director			6. Sex 7. Age (In yrs. last birthday) 83 Yrs.				Days	Hours	Min.	MAR . 1	Date of Birth (Month, Day, Year) 26 9. Birthplace (State or Foreign MD • MD •			
	Maryland	tor	10a. State 10b. County 10c. City, Town or Location											10d. Inside City	
	with the	i Director	10e. Street and Number 10200 LA PLA	TA ROAD			10f. Zip	Code 206	46			10g. Citizer	of What Co	untry?	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.	ırs after death il', or iteme 23 Xaminer mus	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Deceder Armed Forces 1 Tyes 2 V If Yes, Give	?		Was Deced t Yes, spec		panic Orig , Mexican, Specify:	gin? (Spe , Puerto I	crfy Yes or N Rican, etc.)		Race - Amer Black, White ecify: AME		AN
	t within 72 hou liene. r than "nature the Madical E	Completed by	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	life. I	ient's Usua kind of wor DO NOT us STOD	rk done di se retired)	uring most	of working	16b. Kind of Business/Industry CHARLES CO. BD.OF EDUC.			o.			
land?	uld be filed Jental Hyg rkad othar itic evant,	To Be C	17. Father's Name (First, Middle, Last) 18.									e, <i>Maiden S</i> u MPSON			
, Mary	and 2 sho alth and N 27 le ma		19a. Informant's Name/Relationship JOHN T. SWANN-B			4745	BRI	ERWC	OD R			ber, City or To			
Baltimore,	Pages 1 and of He int: If Item		20a. Method of Disposition  12 Burial 2 Cremation 3 (4 Donation 5 Other (Special Control of Control	□Removal from Stat	20b. Pi	lace of Dispo emetery, crer JOSEP	sition (Name natory or o H S	ne of ther place CEM •	"   a	0 -5-	0 9	20c. Locat	ion - City or T		
Balti	permit. Departm Importa any Inju		21. Signature of Juneral Service Lice	nsee M0047	9	222 R. L.	Name an AYMO A PL	d Address ND F ATA,	ot Facility UNER	AL 206	SERVI 46	CE,P.	Α.		
)	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Finat disease or condition resulting in death)  Due to (or as a consequence of):										een eath		
8760,	sate be executed EXA  ohysicien and ithe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Ener underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	is a consequ	ience ot):									
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 gronths? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (									23d. Date of delivery  Month Day Year			ear .
	quires that the de n signed by the a lid be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									tobacco use		the cause of de	
al Reco	i: The law requiri icate has been si r, page 2 should t	Completed									24a. We aut per 1 Yes	opsy formed2	prior to death?	topsy findings as completion of car 2 No	variable use ot
of Vita	hysicien his certifi il director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ tnpa		ER/Outpatier			r. 4 Nui	• •	n <i>(Check only</i> ne 5□ Re	one) sidence 6	Other (Spec	cify)	
Division of Vital Records, P.O lor Attending Physicien: The law requires that the	To the Hospital or Attending Physiclen: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	27. Manner of Feath    Matural   5   Pending investigation     Suicide   4   Homicide   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury at Work?     M   28c. Injury at Work?   M   1   Yes   2   No   28d. Describe how injury occurred     28d. Describe how injury								iral Route Numb	er,			
Ω	Hospital of thours af uneral Dispitited in	edicai Cer	29a. Certifier 1 Cartifying P	hysician: To the bes	st of my know	wledge, death	n occurred	at the time	e, date and	d place, a	and due to th	e cause(s) an	d manner as	stated.	
	vithin 24	Med	29b. Signature and title of certifier	and manner:	stated.	·	290	. License	number			29d. Date s	igned (Montl		
			30. Name and address of person who	completed cause of	death (Item	23а) (Туре,	Print)	100 5	291	7	,	1/3	31/0	7	444
	Sta	ite	Jarnes // 31. Date filed (Month, Day, Year)	Qrning 32. Plegis	2 strar's Signa	O) C	ente	enn;	4/ =	ST	4	7/3	4 1	np 200	546
	Registi	ar	AUG V 6	THE COUR	en o	B. 39	BURE								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 July 22, 1:00 A M Robert Deane Thulman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Clarksville Howard 11814 Chapel Bells Way If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. Jan 19, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days 1 XM 2 □ F New York 79 214-28-3966 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City. Town or Location 1 ☐Yes 2 No Clarksville Howard 10g. Citizen of What Country? 10f. Zip Code 21029 USA 11814 Chapel Bells Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No **(unk)** 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify: <sup>Specify:</sup>White 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maud Katherine Deane Robert Kelley Thulman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7564 Worline Road Bow, WA 98232 Victoria P. Thulman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Final Journey Crematory 07/23/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 5 Years 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Metastatic Prostate Cancer Due to (or as a consequence of): Due to (or as a consequence of): ce of):

**Physician** /Medical Examiner

sician and burial-trans

attending physician for use as the buria

been signed by the should be detached

page 2 s

certificate

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical

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Completed

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Certification: To

Ca

Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

immediate Cause (Final

1 - For State Registrar

10a State

10e. Street and Number

MD

**Physician** 

Examiner

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

nd Mental Hygiene. marked other than

permit. Pages 1 and 2 sho Department of Health and Important: If item 27 Is m any Injury or other traum once.

1 and 2 should be 1 Health and Mental

filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

/Medical

Director

Funeral

\$

Completed

Be

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disease or condition resulting in death)

23b. Was decedent pregnant

1 ☐Yes 2 ☐No

9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

1 ☐ Yes 2 🛣 No

27. Manner of Death 1 Natural

2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homicide

c	Due to (or as a consequen
d	1,111

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 3 Ectopic pregnancy

5 ☐ Other (specify)

23d. Date of delivery Month

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated

9 ☐ Unknown

4 ☐ Pregnant at time of death

24a. Was an

1 🗌 Yes

2 No 3 Probably 4 Unknown

autopsy 1 □Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Nesidence 6 Other (Specify)

23e. Did tobacco use contribute to the cause of death?

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D23601

29d. Date signed (Month, Day, Year) July 22, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward J. Lee, M.D. 11065 Little Patuxent Pkwy. Columbia, MD 21044

Hospital or Attending Physician: The law requires that the death certificate be executed

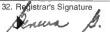
Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year) JUL 2 4 2009

5 Pending investigation

6 □Could not be

determined



			State of Maryland / De	partment of H <i>ertificate of L</i>			ene g. No. 2 0 0 9	25   8
			Registrar  1. Decedent's Name (First, Middle, Last)			2. Date of Death	1	3. Time of Death
	Physicia /Medic		Jeffery M. Travers			Month July 26		1:00 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	_	4c. County of Dea	_
			Fort Washington Nursing Center		ashington If Under 24 Hrs.			George's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Days	Hours Min.	8. Date of Birth (Month, Day, April 8	Year) 3. 0	rthplace (State or Foreign ountry)  Maryland
	Director		217-74-4949 51 Usual Residence of Decedent			APILL	1930	
	ryland how	_	10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits 1 ☐ Yes 2 No
	e Ma	Directo		gton Park				
	vith th	Ë	10e. Street and Number	10f. Zip Code		10	og. Citizen of What C	ountry?
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show calcel Experiment report to rediffed at	Funeral	45821 Lord Baltimore Way  11 Marital Status 12. Was Decedent Ever in U.S. 1	206 3. Was Decedent of H		ecify Yes or No-	USA 14. Race - Am	erican Indian,
•	fter de	표	11√ Never Married 2 Married 1√2√es 2 No	3. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	Black, Whi	te, etc.
5-0036	al",o	ğ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □Yes 2 <u>/□X</u> No	Specify:		Specify:	Black
ر ک	72 ho	Completed	(Specify only highest grade completed) (G	cedent's Usual Occup	during most of worki		16b. Kind of Business	s/Industry
7	c - 1	ш	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired			Banki	n 07
2	be filed within 7 ttal Hygiene. d other than "r event, II.	ပ္သ	17. Father's Name (First, Middle, Last)	Bank Tell	18. Mother's Name	e (First, Middle, N		<u></u>
Maryland	d be fental ked o	To Be	Frank D. Travers		Do	ra W	halen	
Z Z	shoul ind M i marl umati	F		ailing Address (Street	and Number or Run	al Route Number,	City or Town, State,	Zip Code)
Ĕ	and 2 salth a							rk, MD 20653
ore.	es 1 a of He of He fitem			sposition (Name of crematory or other place			20c. Location - City of	
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify)   St. Mar	k's U.A.M.			Valley Le	
Baltimore,	permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importment. If item 27 is marked oth any injury or other traumatic event once.		21. Signatur Tuneral S. rusa Licenson Edward N. Brinsfield. Jr. M00052	22. Name and Address 22955 Holl				
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
I.	Physician		Immediate Cause (Final disease or condition Advanced HIV	Disease				Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):					
	Examiner	er	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):					
_	ted nsit	ni e	Cause (Disease or injury					Î
	execu n and al-tra	Examin	that initiated events c					
68760	ificate be executed physician and is the burial-transit	edical	d					
9	rtifica ng phy as th	ledi	(F. FF.) (1) (F. FF.) (1) (F. FF.) (F.		-			
Box	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy   23b. Was decedent pregnant   1 Live birth 2 Fetal death   1 Live birth 2 Fetal death   1 Live birth 2 Live birth	3 ☐ Ectopic pregnanc	ÿ		23d. Date of o	lelivery Day Year
0	ie dea the at ned fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 ☐ Other (specify) _				- 17
<u>.</u>	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	en in Part I.	23e. Did to	pacco use contribute	to the cause of death?
Vital Records,	signe d be	d by				1 □ Y€	es 2 No 3	Probably 4 Unknown
Š	w requ	Completed				24a. Was a	n 24b. Were	autopsy findings available o completion of cause of
Æ	The lay ate has bage 2	Ę.				autops perforr 1 □Yes	ned? death	o completi <i>o</i> n of cause of ? es 2 □No
ta	Physician: The lav this certificate has al director, page 2	ര	25. Was case referred to medical		26. Place of Deat			55 2 LINO
<u>&gt;</u>	nysici nis cel direc	O B	examiner? 1 Yes 2 100 Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Oth	ner: 4 Nursing H	ome 5 ☐ Reside	ence 6 Other (S	pecify)
0	ng Pł	L:uo	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Tim (Month, Day, Year) 28b. Tim	ry Wor		28d. Describe ho	ow injury occurred	
20	tendi eath. or: A the fu	catio	2 Accident investigation		]Yes 2□No	006 1		Cumi Bauta Number
Division of	or At ifter d Direct in by	Certification: To	3 ☐ Suicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		City or Town	n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	leath occurred at the ti	ime, date and place	e, and due to the o	cause(s) and manner	as stated.
	e Hos n 24 h e Fun letely	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/one)  and manner stated.	or investigation, in my	opinion, death occu	rred at the time, o	late and place, and d	ue to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. Licens	se number	2	29d. Date signed (Mo	
	1		) color	D42	955		7/30/20	09
	7		30. Name and address of person who completed cause of death (Item 23a) (Ty				MD 007//	
			Edger Potter 11701 Livin	gston Rd.,	Ft. Wash	ington,	MD 20744	·
	Sta Registi		31. Date filed (Month, Day, Year) 2009 2. Registrar's Signature	all				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month 22:30 PM **Physician** rence 07 18 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ummc 1 Year of Under 24 Hrs.
Days Hours Min. 8. Date of Birth (Month, Day, Year) 10 18 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 2M 2□ F Months 218.40.744 66 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Experiment rest be rediffed at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 Yes 2 No Chestertown Director KENT mD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 216.20 539 HIGH STREET USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify: DIACK ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1140 HAndy man 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLARENCE TURNER SE IdAL. Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DETTYAMPE TURNER. SISTER 539 HIGHST. Chestertown mo 21620 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-24-09 Chestertown, MD 22. Name and Address of Facility \* ENNE THE WAILEY FUNERAL SERVICE 21. Si mature of Funeral Service Licen ee 602W 821 W.ST. ANNAPOLIS, MARY LAND 21401 Approximate Interval Between Onset and Death 23a. Prt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 days Physician LEFT MCA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after deatt

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 2009 7305 **Physician** Oddie Flora Titus ILL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🛣 F 214-14-3807 3, 1920 88 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai", or Items 23a or 28a-f show Examiner must be notified at 1∑Yes 2 No Director Md. Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A 1175 Professional Court "natural", or Items 23a Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within ealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Excavation 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Windsor Thomas Collins ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 15210D Motters Station Rd. Rocky Ridge, Md. 21778-971 Thomas L. Collins (Son) permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Smithsburg Crematory 2009 Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Service Licensee 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 Smi :

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Sn Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cento Varhe A Chil. and the /Medical Due to (or as a consequence of): **Examiner** sut myound Sequentially list conditions, if any series of the Conditions of t Due to (or as a consequence of) Examiner requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year ģ 5 ☐ Other (specify) P.0. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 Prishty Malletin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ANO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: the 1 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier - costs MO D18019 JULY 29 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugeistown, MD 340 street ·mo 32. Registrar's Signature

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State Registrar

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		•	Brooke Grove Rehabiltation & Nursing				M	ontgome	ry		
	neral ector		5. Social Security Number 6. Sex 7. Age (In <b>Security Number</b> 1. Sex 1. Age (In <b>Security Number</b> 1. Sex 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number</b> 1. Age (In <b>Security Number 1. Age (In Security Number</b>	Months Days Hou		8. Date of Bir (Month, Di	<i>ay, Y</i> ea	r)	Birthplace Country) rth		
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(17.13-103-0030) within 72 hours after death with the Maryland fiene. fiene.	It Modical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	<ul><li>13. Was Decedent of Hispanic If Yes, specify Cuban, Mex</li><li>1 ☐ Yes 2☐No Specify</li></ul>		Rican, etc.)	0-	14. Race - A Black, W Specify:	hite, etc.		
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Dallinore, permit. Pages 1 an Department of Hea	or other		1 De Burial 2 I ICremation 3   Bernoval from State	isposition (Name of crematory or other place)	1	/2000		Location - City			
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Physic /Med Exam	dical iner	ler	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading it immediate.		-/		11	M)	D	proximate erval Bet eset and I ays	ween Death
tificate be executed physician and	as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to firmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Configurative field to (or as a consequence of)  c. Due to (or as a consequence of)  d.	SE	MM/	DION DIPROVED BY	MEDICAL	EXAMI			
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The law requires the task been signed	rector, page 2 should be detached	Completed	Renal Insufficiency and Subdural	Hematoma		24a. Was auto perf 1 □ Yes	opsy formed?	? deat	to comple	etion of c	
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To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th	ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Could not be determined  4 ☐ Home  28e. Place of Injury - At home, farm building, etc. (Specify)  Home	, street, factory, office	S	28f. Location City or To <b>ilver</b>	(Street wn, Sta	and Number of ate) 1420 ing, MD	r Rural Ro <b>Peac</b>	oute Num <b>eful</b>	Lane
e Hospil 24 hour 3 Funera	letely fill	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, one characteristics and manner stated.	death occurred at the time, day or investigation, in my opinion	ate and place, n, death occur	and due to th red at the time	e cause e, date a	e(s) and manne and place, and	er as state due to the	ed. e cause(s	s)
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			30. Name and address of person who completed cause of death (Item 23a) (Ty		1	a .		D 00000			
	Sta	te.	Anuradha Arun, MD 10301 Georgia A 31. Date filed (Month, Day, Year) 32 Registrar's Signature		Gilver_	Spring	او_و	D 20902			
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State of Maryland / Department of Health and Mental Hygiene ? [] [] 9

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Baltimore, Maryland 21215-0036	Pages 1 nent of H ant: If iter ary or oth			•	3 Removal from	State	20b. Place of cemetery				Ú	ulv	31, 20	<del>)</del> 9	ocation -	,		
alti	permit. Page Department of Important: If any injury or once.		21. Signature of F				Countr	22.	. Name an	nd Addre	ss of Facilit	ty Net	vman Fu	nera	al Ho	mes,	P.A.	•
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<u></u>	ician: The certificate h ector, page		25. Was case refe	rrad to madical							00 Bl	( D	1 □ Yes	2 <b>A</b> N		1 ☐ Yes	2 No	
Š	Physician: this certific	o Be	examiner?	£	Hospital:	Inpatie	ent 2 ER/Out	patien	t 3 🗆 DC	Oth	or:		th <i>(Check only</i> ome 5 ☐ Re		6 □O#	ner (Spec	ifv)	
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Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOWSON, MARYLAND 21204 7601

31. Date filed (Month, 11 Y3") 2009 State Registrar



Medical Ce

D37254

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 27, Day 2009 **Physician**  $A^M$ 4:35 Merrell Edward Wilburn /Medical 4c. County of Death 4h. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Garrett Grantsville Goodwill Mennonite Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** June 12, Days Hours 1 X M 2 □ F Maryland 1912 97 Director 213-22-4484 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Show If than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2X No Directo Accident MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 21520 27129 Garrett Highway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerical Bookkeeper 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 is marked other if any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rebecca Jane Pysell James Gregory Wilburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21536 94 Main St., Grantsville, MD James O. Wilburn/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Hoyes United Meth. Cem. July 30, 2009 Friendsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Libensee P.O. Box 275, Grantsville, MD Approximate Interval Between Onset and Death Part1. Enter the diseas of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Find **Physician** ongestive resulting in death) /Medical Due t / r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending phase as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f I□Yes 2□No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 Yes 2 No 3 Probably 4 Nnknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No certificate 1∐ Yes 2 No 1 ☐ Yes the Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death, o the Funeral Director: A ompletely filled in by the fi 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number July 27, 2009 D-34231 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21536 Robin Bissell 124 Miller St., Grantsville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

State Registrar

OPIGINIAL

			For	State	of Marylan			lealth and I	Mental Hy	giene	00 05100
			State Registrar			Cei	rtificate of	Death		Reg. No. 201	
	Physicia	an l	Decedent's Name (First, Middle	e, Last)					2. Date of De Month	Day `	Year 0:630 A M
	/Medic	al	Betty Jean Wil				41 07 7	und a catilea of Dooth	7	21 200 4c. County o	09
	Examin	er	4a. Facility Name (If not institution					or Location of Death	П		
	F		Manor CAre Nur  5. Social Security Number	sing HOme	7. Age (In yrs.	last birthday)	Chevy C	If Under 24 Hrs.	8. Date of Bir	Montg	9. Birthplace (State or Foreign
	Funeral Director		578-46-4986	1 □ M 2 🕱 F		76 Yrs.	Months Days	Hours Min.	(Month, Da 10/16/		NC_
N.			Usual Residence of Decedent								10d. Inside City Limits
	rylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1⊠Yes 2 No
	e Ma	Director	DC None		Was	shingto				10g. Citizen of Wi	
	vith th		10e. Street and Number				10f. Zip Code			0	nat Country:
	hours after death with the Maryland tural", or items 23a or 28a-f show al Evorring transition at	Funeral	5736 27th St. I		cedent Ever in U	S 13 1	20015	Hispanic Origin? (S	Specify Yes or No	USA 14. Race	- American Indian,
	ter de	Fun	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Mar</li></ul>	Armed F	orces? 2 🔂 No		If Yes, specify Cub	oan, Mexican, Puert	to Rican, etc.)	Black	, White, etc.
036	urs at al", o	by	3 ☑ Widowed 4 ☐ Divorced	If Yes. G			1∐Yes 2⊠No	Specify:		Specify:	Black
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2	be filed within 72 hours after death with the Marylan Hygiene.  d other than "natural" or items 23a or 28a-f show event, the medical Expirement out the medical Expirement.		11th	( ant)		Catet	eria Mar		me (First Middle	DU PUDI e, Maiden Surname	ic Schools
anc	be fill he fill he ded of the fill he ded of the contract of the fill he ded of the fill	Be	17. Father's Name (First, Middle,						a Baile		,
Maryland 21215-0036	2 should be filed within 72 I and Mental Hygiene. is marked other than "nat raumatic event, the Media	٩	William Baile  19a. Informant's Name/Relations			19b. Mailir	na Address (Stree			ber, City or Town, S	State, Zip Code)
	nd 2 s llth ar 27 is rtrau		Tilli William		r		27th St			DC 20015	
Baltimore,	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		20a. Method of Disposition	5) daugnee	20b.		sition (Name of matory or other pla		Date		City or Town, State
Ë	Pages nent of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State Ma	rvland	Nationa	1 ! - 10	27/2009	Laure1,	MD
a	permit. Page Department of Important: If any Injury or once.	1	21. Signature of Funeral Service		e	merery	2. Name and Addr	ess of Facility Ma	rshall'	s Funeral	1 Home
m	S T E G		Opman	hall	MOO	977	4217 9th	St NW Wa	shingto	n DC 200	11
		i	23a. Part. Enter the disease, o shock, or heart failure. List	complications that only one cause on	caused the dea each line.	th. Do not en	ter the mode of dy	ing, such as cardia	c or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_ a.	MUL	TIPL	5 my	ELOMA	4		Chock and Dean
	/Medical Examiner		resulting in death)	Due to	o (or as a conse	quence of):					
	LXdiiiiilei	e	Sequentially list conditions,	b. Due to	o (or as a conse	quence of):					
	uted I Insit	min	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\$	0 (0) 40 4 00 1100	4.01.00 0.7.					
<u>,</u>	execting and ial-tra	Examine	resulting in death) Last	C. Due to	o (or as a conse	quence of):					
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89	ertifica ing ph as th	Med	IF FEMALE:		-						
. Box	eath certific aftending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregree birth 2 Fet	al death 3	Ectopic pregnar	псу		23d. Date Mor	e of delivery nth Day Year
0	at the dea by the a tached fo	/sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ∐ Pre 9 ☐ Uni	egnant at time of known	death 51	Other (specify)				
<u>Р</u>	that the ed by detac	Ph	Part II. Other significant condit	ons contributing to	death but not re	sulting in the u	inderlying cause g	iven in Part I.	23e. Did	tobacco use contr	ibute to the cause of death?
ds,	uires that signed I	d by							1	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
00	w requir s been s should	Completed							24a. Wa		Vere autopsy findings available
æ	he law te has age 2 a	m d							aut per 1 □ Yes	formed? d	orior to completion of cause of death? I ∐Yes 2∰No
ta	an: 7 rtifica tor, p	Be C	25. Was case referred to medica	ıl [				26. Place of De	eath (Check only	,	
>	nysici nis ce direc		examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	] Inpatient 2	☐ ER/Outpatie	nt 3□DOA	ther: 4 Nursing	Home 5 ☐ Re	sidence 6 □Othe	er (Specify)
Division of Vital Records,	ding Physician: The I h. After this certificate ha funeral director, page	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendi	(1.4)	te of Injury onth, Day, Year)	28b. Time o	We		28d. Describe	e how injury occurre	ed
Sio	tendi eath. or: A the fu	cati		igation				⊒Yes 2□No	006 1	(Ot and an all through	anas Dural Route Number
$\leq$	or At ifter d Direct in by	ıţ	4 ☐ Homicide determ	nined   286, Plac	ce of Injury - At I Iding, etc. <i>(Sp</i> ec	nome, tarm, st sify)	reet, factory, office		City or To	own, State)	er or Rural Route Number,
u	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certify	ng Physician: To t	he best of mv kr	nowledge, dea	th occurred at the	time, date and place	ce, and due to the	ne cause(s) and ma	anner as stated.
	24 hos 24 hos Fun etely	Medical	(Check only 2 Medica one)	I Examiner: On the	basis of examir anner stated.	nation and/or i	nvestigation, in my	opinion, death occ	curred at the time	e, date and place, a	and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certific					nse number		29d. Date signed	d (Month, Day, Year)
	10			Luß	ens, in	S	200	05712	4	7/2	3109
	00		30. Name and address of person	who completed ca	use of death (Ite	em 23a) (Type	, Print)				
	tel		Tiruang Bao,				vn Rd. Be	ethesda,	MD. 208	17	
	Sta Registr		31. Date filed (Month, Day, Year	2009	Registrar's Sign	lature San	Kand				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2000 /Medical tion, give street and number) Montgomery Villa Health Care Center (If not institution 4c. County of Death 4b. City, Town, or Location of Death Examiner Village Montgomery Gaithersburg der 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. India Nov 3, 84 Director 212-47-1992 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County Pages 1 and 2 should be filled within 72 hours after death with the Marylan nent of Health and Mental Hygiene. The state of Health and Mental Hygiene and state of Health and Mental Hygiene and state of Health and Mental Hygiene than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at show 1 TYes 2 No Director Germantown Maryland Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number India 20874 17704 Smokewood Drive by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Saltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced Asian-Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medicine 12 Pharmacist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dayaram Virbaiben Dayaram Harji ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 17704 Smokewood Drive Germantown, Maryland 20874 Ambaben A. Oza/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crematory 8/3/2009 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licens thomas ianta ( 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, showly or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any leading to firm, diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conse Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical liven IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? signed by but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 🗌 Yes 2 \ No

Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: filled in by

6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier (Check only one) 29b. Signature and t

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 120057574 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmad Heshmat 10110 Molecular Dr. Suite 200 Rockville, Maryland 20850

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

To the

		-	- State Registrar amend 1 per	Dr. g894 8/7			ntai Hygie Reg.	0000	25190
			Decedent's Name (First, Middle, Last)			2.	Date of Death	Day Year_	3. Time of Death
10	Physicia /Medic			Daby GIII A	dictiony		S C	15 1000	10000 ym
	Examin		4a. Facility Name (If not institution, give		,	Location of Death		4c. County of Deat	
	-		5. Social Security Number 6. Sec		st birthday) If Under 1 Year		Date of Birth	MO N76 9. Birt	hplace (State or Foreign untry)
-	Funeral Director		W/A I	M 2007F	Yrs. Months Days	Hours Min.	Month, Day, Ye		JRYLAND
	and		Usual Residence of Decedent  10a, State 10b. County	10c. City,	Town or Location		<u> </u>		10d. Inside City Limits
	Maryla f sho	to	MD MONTG	OMBOYCI	VER SPY	SING			1 Nes 2 No
	r 28a	Director	10e. Street and Number	01.561216	10f. Zip Code	(1140)	10g.	Citizen of What Co	untry?
	th with	a D	11518 STEWA	RT LANE	31 209	04	L	ISA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify In, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 YNever Married 2 Married 3 Widowed 4 Divorced	1  Yes 2 No If Yes, Give Year or Dates:	1 □Yes 2 127No	Specify:		Specify:	HOCK
9	2 hou latura	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Decedent's Usual Occup (Give kind of work done)	ation	168	o. Kind of Business/	
21	ithin 7 ne. Nan "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired	1)			215
121	led w Hygier her th	S	17. Father's Name (First, Middle, Last)		INFA	18. Mother's Name (F	irst. Middle, Mai	den Surname)	100
anc	d be fi	Be		NOAOU		TURN		- home	Y UNG H
Σ	should nd Me mark matic	မ	19a. Informant's Name/Relationship (7)		19b. Mailing Address (Street				
ž	and 2:		HOLY CROSS	HOSPITAL	1500 FOR	EST GLE	EN R	1 22 0	01805 04
ore	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20b. Pla	ace of Disposition (Name of metery, crematory or other place	Date	200	c. Location - City or	Town, State
Ĕ	Pag tment tant: I		4 ☐ Donation 5 🖾 Other (Specify)	in state					
Baltimore, Maryland 21215-0036	permit Depar Impor any In once,		21. Signature of Funeral Service Licens	ade, Director		ss of Facility Omy Board 6	55 W. B	altimore	Street
			23a. Part 1 Enter the disease, or come	cations that caused the death.	Baltimore, Do not enter the mode of dying		espiratory arrest	,	Approximate
	Dhysisian		shock or heart failure. List only o	ne cause on each line.		*	-4		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseque		cicaci	1 1		
	Examiner		Convention list conditions	b					
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ninck of):				
	xecute and II-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):				
68760,	ifficate be executed g physician and as the burial-transit	edical E		d					
_	ng ph	Medi	IF FEMALE:			14.5-3			r
Box	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal (	death 3 Ectopic pregnance	у		23d. Date of de Month	livery Day Year
o.	Physiclan: The law requires that the death cer r this certificate has been signed by the attendin ral director, page 2 should be detached for use	Completed by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	ath 5 Other (specify)				
, A.	s that ned by detail	y Ph	Part II. Other significant conditions co	ntributing to death but not result	ting in the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
45	en sig	ed b					1 🗆 Yes	2 12 No 3 □ P	robably 4 🗌 Unknown
力 Division of Vital Record	law re as be 2 sho	plet					24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>~</u>	: The cate h page	Con					performe 1 □ Yes 2 6	d? death? ZNo 1 ☐ Yes	s 2 No
Vita	iclan certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:	Oth	26. Place of Death (Coner:			
o	Phys r this ral dir	-: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 L E	28b. Time of 28c. Inju	ry at 280	5 ☐ Residend  d. Describe how	ce 6 ☐Other (Spe injury occurred	ecify)
On	Attending r death. ector: After by the fune	ition	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury Wor	kí? Yes 2 □No			
<u> S</u>	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	me, farm, street, factory, office	28f	Location (Stre	et and Number or Fi State)	ural Route Number,
Ö	ital or A				_				
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death occurred at the t ion and/or investigation, in my	me, date and place, an opinion, death occurred	a due to the cau at the time, dat	ise(s) and manner a e and place, and du	e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	, )	29c. Licens	se number	290	I. Date signed (Mon	th, Day, Year)
			) 1 50 hu		D 2	6153	0	5 15	2009
	<i>'</i>		30. Name and address of person who c				20 0	224 )	10010
			31. Date filed (Month, Day, Year)		DO FOREST	GLEN (	5D S	2- WO	OIPUL.
	Sta Registr		MAY 2 1 200	3/. Registrar's Signat	parke				
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month POWS **Physician** /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Severna ARK INING POUNDAL UNRISE 8. Date of Birth (Month, Day, Year) 2/21/1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country Months Days 1 □ M 2 🕅 F 92 217-16-8378 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, In Marcial Expression 1000. 10d Inside City Limits 10c. City, Town or Location 10b. County 10a. State MDANNE ARUNDEL SEVERN 1 □Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21144 Funeral 769 Jennie Drive 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white Specify. \$ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Office Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Rog George Korycki ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janice Andrews/daughter in law 771 Jennie Dr Severn MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8/5/2009 Glen Burnie MD Glen Haven Cemetery 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA vice Live 21. Signwure of Fu eral S M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YOCARDIAL IN FARCTION **Physician** ACUTE HOUE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. ned by the a detached t 9 Unknown 9 Unknown signed I be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2₽No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 : autopsy performed 2 No certificate CORONAR 2. No 1 ☐ Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 14000 Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1. Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. Pate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SEASONS HOSPICE AT NORTHWEST HOSPITAL RANDALLSTOWN 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number Age (In vrs. last birthday) **Funeral** Hours 1**X** M 2□ F Months Days POLAND 218-34-1270 93 h2-16-1<u>916</u> Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County 1 Yes 2 No Director MD BALTIMORE OWINGS MILLS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4730 ATRIUM COURT #421 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: 3 X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GROCERY MERCHANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEIB RACHEL HORN ပ ABRAMOWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11604 WOODLAND DRIVE, LUTHERVILLE, MD 21093 ROSA APPLEFELD/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | REISTERSTOWN, MD BALTIMORE\_HEBREW 108-06-2009 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ĝ 2 No 3 Probably 4 mknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital: 1 Yes 2√No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed and After this n 24 hours after death.

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Baltimore, Maryland 21215-0036

d other than "natural", or items 23a or 28a-f shovevent, the Wedest Even, and persettled at

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

07

32 Registrar's Signature

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 **Physician** Hiawiatha Burke Norman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Franklin Square Baltimore Hospita Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Months Min West Virginia **Director** 236 20 7792 85 01/13/1924 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov or other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Directo Maryland Baltimore Essex 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21221 USA or Items 23a 2614 Holly Beach Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXVo Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, It. Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Bethlehm Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Ann Kearns Leo Burke မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 Holly Beach Road Essex Maryland 21221 Michelle\_Chilton (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 8/8/2009 Baltimore Maryland 4 ☐ Donation Other (Specify) 21. Sign Hure of Full 22. Name and Address of Facility Bruzdzinski Funeral Home PA al Servic cicens 1407 old Eastern Avenue Essex Maryland 21221 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ist only one cause on each line. Enter the diseas or heart failure. Immedi te lause (Final disease r indition resulting in eath) Onset and Death **Physician** /Medical Due to ( r as a consequence of Examiner sothelior Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 2 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death
1 Natural
2 Accident Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State

Registrar

31. Date filed (Month, Day, Year) AUG 07 2009

30. Name and addr

32. Registrar's Signature

s of person who completed cause of death (Item 23a) (Type, Print)

Ke300000

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 08-05-2009 Day **Physician** 0720 Margaret E. Borys /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours Min. 1 □ M 2 🖾 F 05-05-1958 MD 218-68-7506 51 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Director Bel Air Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 304 Locust Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wealth Management Sol. Financial Advisor Important; If item 27 is marked other i any injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jean Donald Paul G. Morin, Sr. ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 304 Locust Lane Bel Air, MD 21014 Daniel Borys (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08-12-2009 Fallston, MD Highview Mausoleum 4 □ Donation 5 XOther (Specify) Entombment 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metasta to remain Due to (or as a consequence of): Physician /Medical Pericardial Effusion Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Ongestive Itean-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □Vo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Carcinoma 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ► ER/Outpatient 3 ☐ DOA 1 □ Yes Certification: To 27. Mannef of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical

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attending physician and for use as the burial-trar Hospital or Attending Physician: 24 hours after death. Funeral Director: tely filled in by the 24 To the I

ed other than "natural", or items 23a or 28a-f show event, the the field Evan in the most be notified at

Baltimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

Department of

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29a, Certifier

Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

chesapeake Drive, Bel Air, MD 21014 32. Registrar's Signature 31. Date filed (Month, Day,

State Registrar

09-06057	
Terry Brown	

9-06057 erry Brown		Please Type or Print in Black Indelible State of Maryland / Departmen	e In	k. Ens	ure	All Co	pies	Are Leg	ible		
	F	1- For State Certificate			anu				g. No.	200	9 25   9
Physicia Iedical Examir		1. Decedent's Name (First, Middle,Last)  Terry John Brown						Month August 3, 2	Day 2009	Year	1736 hrs
		4a. Facility Name (if not institution, give street and number)  Baltimore Washington Medical Center	4	b. City, Tow Glen Bu		ocation of I	Death			County of Death nne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay)	If Under 1	_	If Under 2	_	8. Date of Birt	h(MM/I	Foreign	thplace (State or
Director		379-82-8001 1XM 2F 45	Yrs.	Months	Days	Hours	Min.	May 30	), ]	L964 Co	untry) Michigan
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Locatio	on							10d. Inside City Limits
Aaryland 28a-f show 1 at once	후	Michigan Lapeer Metamora		10f. Zip Co	nde.		<del></del> -	110	n Citiz	zen of What Cou	1 Yes 2 X No
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. team 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once	Director	3178 Hillview Drive		4844						S.A.	
n with the mas 23;	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1			of Hispa			cify Yes or No-			ican Indian, Black,
ter deat		1 X Yes 2 No		Yes 2 y	,					Specify: Wh	ite
ours af	d by	15. Decedent's Education (Specify only highest grade completed)  16a. De	cedent	t's Usual Oc	cupatio	n (Give kir			16b. k	Kind of Business	
136 hin 72 h e. than "r	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		c Driv					Тт	ransport	ation
5-00 led with Hygien other	5	17. Father's Name (First, Middle, Last)	<u>ucr</u>	CDILV	18	3.Mother's	Name (F	irst, Middle, M Blondi	Maiden		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumarite event, the Medical	To Be	John William Brown  19a. Informant's Name/Relationship (Type, Print )  19b. I	Mailing	Address (				Bo <b>ndin</b> ral Route Nun		ity or Town, Stat	e, Zip Code)
MD 2 nd 2 shou lith and I m 27 is r aumatic		Pamela Denise Brown Wife 31	.78	Hillv	iew	Dr.	Ме	tamora	, Mi	ichigan	48455
of Heal		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory			of cem	etery,		Date	20c.	Location - City o	r Town, State
Baltimore, permit Pages Lan Department of Hea Important: If iter		4 Donation 5 Other Specify: Oakvie 21. Signature of Funeral Service Licensee		emeter			8/1	0/09	Ro	yal Oak	, Michigan
Balti permit Departm Imports injury c		3a Part I. Efter the disease, or complications that caused the death. Do not of	CF	narles	S	7.e i 1	ler d	& Son, <u>Balti</u> r	Inc	MD 2	1224
Physician /Medical		failure. List only one cause on each line.							est, sho	ock, or heart	Approximate Interval Between Onset and Death
-xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic condition resulting in death)	ard	10Vas	cula	ir al	seas	:e			
	-E	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):		-					-		
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recuted styl	न	d.	ME.	g894	8/1	1709	TT				
60, ate be ex hysician e burial	Medic	X UNPENDED  X AMENDED 23a,27,per I tem#18per IN  IF FEMALE: 23c. If yes, outcome of pregnancy	F.0	3894 <b>,</b> 8	/1/	09,WS	3		23	d. Date of delive	ry
Box 68760, e death certificate be ex the attending physician ed for use as the burial	jan/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Pregnant at time of death 5		tal death her (Specif)	_	Ectopic	pregnan	су		Month	Day Year
Box e death the atte	Physician/Medic	1 Yes 2 No 9 Unknown 9 Unknown									
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Recol The law cate has page 2 st	Somp							perfo 1 ✓ Yes	rmed?		
ital Rec sician: The s certificate irector, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ▼ ER/Out	natient		10	of Death ( Other			Resid	ence 6 Oth	er:
of V ng Phys	n: To	27. Manner of Death 28a. Date of Injury 28b. Ti				y at Work?		28d. Describe			
Division ral or Attendi rs after death al Director: /	catio	1 X Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 28e. Place of Injury - At home, fam	n atro			es 2		28f Location (	Street	and Number or F	Rural Route Number, City
Division or a state or	Certification:	3 Suicide 6 Could not be determined (Specify)	n, sue	et, lactory, c	mice bi	inding, etc	. 8	or Town,		and trained of	
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi completely filled in by the funeral director,	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one)  Medical Examiner: On the basis of examination and/or inv	n occui estiga	rred at the ti tion, in my o	me, da pinion,	te and placed	ce, and o	due to the cau	se(s) a and pl	nd manner as st lace, and due to	ated. the cause(s)
To with	Mec	and manner stated.  29b Signature and title of certifier		29c. l	License	number			1	- '	fonth, Day, Year)
		tati Un-Hollers			0.C.N	Л.Е. 			Au	gust 4, 2009	
$\phi$		Name and address of person who completed cause of death (Item 23a)     Patricia Aronica-Pollak MD. Assistant Medical Examin	ner	111 Per	nn Str	eet, Ba	Itimore	e, MD 2120	)1		
St Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	128	K.							
1.66191		ALLE ALLERS AND AND AND AND AND AND AND AND AND AND									

State 31. Date filed (Month, Day, Year)
Registrar

#20b Per FH G8 Parte 8/ War Pland Department of Health and Mental Hygiene amend 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AM PESYA **BEYDER** AUGUST 6 2009 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Age (In yrs. last birthday) 1 □ M 2 X F Months Days Hours Min. 09-15-1912 **Director** 217-39-6603 96 UKRAÍNE Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f shore Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 SUNTOP COURT #202 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ MOISHE BEYDER GOLDA NEINSHTUT permit. Pages 1 and 2.
Department of Health an.
Important; If item 27 is m.
any injury or other-19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYUDMILA LIPSMAN/DAUGHTER SUNTOP COURT #202, BALTIMORE, MD 21209 20b. Place of Disposition (Name of BACETYMENT) Page 120c. Location - City or Town, State BACETYMENT LAWE 08-06-09 REISTERSTOWN, MD 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician schamic Cordonyopatz disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading terminoliate cause. Enter Underlying Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 □ No 1 □ Yes 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Wosput 1 Tes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 6 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAZUES M 6701 N. Charles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

			For State Registrar	State of Ma		artment of I rtificate of				giene Reg. Nø.	09	25197
	$0.1 \pm 3$		Decedent's Name (First, Middle, Las	t)					Date of De	ath		3. Time of Death
	Physici		LOUIS BECK					A	Month ug ust	Day <b>2</b>	Year 2009	12.20 PM
	* /Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location		ng voi		unty of Death	
	LXdiiiii		BALTIMORE EXTENDE		(ME CENT	150	134-	7/mire	-		N/	Α
-	Funeral				(In yrs. last birthday,	If Under 1 Year	If Under	24 Hrs. 8	Date of Birl	th Vaar	9. Birth	place (State or Foreign
	Director		048-09-2099	M 2□F 9	O Yrs.	Months Days	Hours	Min. (	(Month, Da )4/13/	1919	Cot	CT
	D		Usual Residence of Decedent									
	show		10a. State 10b. County		10c. City, Town or L							10d. Inside City Limits 1 X Yes 2 □ No
	e Ma 3a-f s	cto	MD N/A		BALTI	MORE						
	death with the Maryland ms 23a or 28a-f show r must be notifled at	Director	10e. Street and Number			10f. Zip Code					of What Cou	intry?
	ath w	ra	3900 LOCH RAVEN			21218					SA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ender Forces?	ver in U.S. 13.	Was Decedent of I	Hispanic Or oan, Mexica	igin? (Specif in, Puerto Ric	y Yes or No an, etc.)	- 14.	Race - Amer Black, White	
98	or if	by Fu	1 Never Married 2 Married	1X Yes 2 No If Yes, Give	0	1 ☐ Yes 2 <b>X</b> ☐ No	Specify			Sp	ecify: WH	ITE
21215-0036	be filed within 72 hours after death with the Marylar tital Hyglene.  do other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	100 000	d	4'			10h 16i1	of Deciment	-44
5	"nat	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	edent's Usual Occu e kind of work done DO NOT use retire	durina mos	st of working		TOD. KING	of Business/I	ndustry
12	within ene. than	m d	Elementary/Secondary (0-12)	College (1-4or 5+ 5+	-)	NTER-INTE		NCE		115 1	MILITA	DΥ
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ano	12 should be filed within 'n and Mental Hygiene. h amarked other than "' raumatic event, <u>the Mec</u>	) Be	HYMAN	BECK				ORENCE				NOVSKY
7	hould mark mark	일	19a. Informant's Name/Relationship (7		1	ing Address (Stree				er City or To		
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		CINDY FOX / DAUG			PLACID CO				2101		,,,
é,	of Health of Health item 27 i		20a. Method of Disposition	IIICK	20b. Place of Disp	osition (Name of		Date			ion - City or	Town, State
<u></u>	Pages nent of I int: If ite		1 Burial 2 Cremation 3 🛛	Removal from State	ARL INGTON	ematory or other pla		08/24	/2009	FOR:	T MYER	S VA
Baltimore,	artme ortan Injur		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	·		2. Name and Addr						*
Ba	permit. Pages Department of Important: If it any injury or once.	- 8	1 1 18	1/2000		900 REIST						
			23a. Fart1. Enter the disease, or comshock, or heart failure. List only	Hications that caused t								Approximate
	<b>D</b>		shock, or heart failure. List only	one cause on each line	1.							Interval Between Onset and Death
Š	Physician /Medical		disease or condition resulting in death)	a	consequence of):	FAILUR	E					
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8760	ate be executed hysician and the burial-transit	dical		d								
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Box	ndin use	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome p	of pregnancy					230	I. Date of deli	very
_	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t		□Ectopic pregnand □ Other <i>(specify)</i> _	СУ				Month	Day Year
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	requires that the een signed by th rould be detache	by P	Part II. Other significant conditions of	ontributing to death bu	t not resulting in the	underlying cause gi	ven in Part	l.	23e. Did 1	tobacco use	contribute to	the cause of death?
rd	quire en sig uld b	b b	Congest	hus hear	+ Failur	VE			1 🗆	Yes 2□	No 3□Pr	obably 4 Mknown
00	iaw re as bee 2 shor	lete							24a. Was		24b. Were au	topsy findings available
R	siclan: The law certificate has I irector, page 2 s	Completed								ormed?	prior to death?	completion of cause of
tal	an: tifica tor, p		25. Was case referred to medical			-	26 Plac	e of Death (	1□ Yes	2 No	1 🗆 162	211110
>	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	ent 3 DOA Ot	hor:				Other (Spec	cify)
Division or Vital Records,	g Ph er thi		27. Manner of Death	28a. Date of Injury		of 28c. Inju				how injury o		
<u>o</u>	Attending r death. ector: After by the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		Yes 2	]No				
Vis.	Afte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injur	ry - At home, farm, s . (Specify)	treet, factory, office		28	f. Location (	Street and N	Number or Ru	ıral Route Number,
	s afte	Ser		Janoning, oto	. (0,000.7)				ony or ro	mi, Olato)		
1	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification:		ysician: To the best on the basis of								
15	he H in 24 he F iplete	edic	one)	and manner stat	ted.				at the time,	, date and pi	acc, and dac	to the cause(s)
1	Vith Vith Common	Σ	29b. Signature and title of certifier			29c. Licen	se number			29d. Date s	signed (Mont	h, Day, Year)
			he /h	1		052	735			Aug	ust 2.	2009
			30. Name and address of person who			Print) Suu	LEST	1 SH	AND	FLI	JA, r	2209 ND mane 21218
			KAITIM ERE REHAN &	LTENDED C	ARE CENT	EX 390	o Loc	4 Ra	12N B	cud	Balto	mane 21218
	Sta	te	PATTIN BYE REHANS & 31. Date filed (Month, Day, Year)  AUG 07 2009	32. Registra	r's Signature	del.						
	Registr	ar	AUG U 7 2009	Lennin	p. 19 an	The state of the s						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene for State Registre Certificate of Death Reg. No. -3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 03 2009 5:45 рм August **Physician** Cromer Theodore Н. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Baltimore** Examiner Rossville Franklin Woods Center 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, June 24, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F 5. Social Security Number Min. Days Hours **Funeral** 1921 88 214-10-0288 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the M. diest Eraci inclination profiled a once. 10c. City, Town or Location 10h County 10a State 1 ☐Yes 2 KNO **Baltimore** Directo Baltimore Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 9104 Covered Bridge Rd. Race - American Indian, Black, White, etc. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🕱 No Specify: White Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Business Owner Elementary/Secondary (0-12) Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frankel Eva Theodore Cromer ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9104 Covered Bridge Rd. Baltimore, Md. 21234 Mrs. Patricia A. Cromer/ Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Md. 8-7-09 Dulaney Valley Mem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Towson Funeral Home, 21. Signature of Funeral Service Licer 1050 York Rd. Towson, Md. 23a. Part 1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DEMENTIA ADVANCED Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown ð Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural i or Attending Fafter death. 5 Pending 1 □Yes 2 □ No after death.

Director: Ald in by the fur investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a

To the Funeral I Hospital 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061789 2009 wuch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OFORTAWUAH, 5430 CAMPBELL BLVD, STE 214, NOTTINGHAM ND 21236 LOPPAINE 32 Augistrar's Signature 31. Date filed (Month, Đay, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 8894 8-26-09 vt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 0806 すっかっ 2009 UR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 13 ex 5151 Pooks hes Va 0me1 / Mell ace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1**√** M 2 □ F 67 140-<del>43-</del>5336 10/30/1941 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, In Medical Eranian. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Carnegie 1¥Yes 2 □ No PA Allegheny **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 15106 Ingrid Place 212 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ∐Yes 2**X** No If Yes, Give Year or Dates Specify: Specify: 9 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Marketing Research 12 5+ Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Smalley Peter John Chomyn Sr. ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 212 Ingrid Place, Carnegie, PA 15106 19a. Informant's Name/Relationship (Type. Print) Pamela R. Chomyn / Wife 20b. Place of Disposition (Name of Pittsburgh Cremation of other place)
Pittsburgh Cremation
Service Date 20c. Location - City or Town, State 20a. Method of Disposition 8/6/2009 1 Burial 2X Cremation 3 Removal from State Pittsburgh, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral HomeInc.
1501 East Fort Avenue, Baltimore, MD21230 21. Signature of Funeral Service Licensee Dorota Marshall willow 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PRITENSIVE CI /Medical Due t ( as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examine requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hote Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier 29b. 2101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD DME 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 7 Registrar

09-05881 Ма

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ry R. Cavey	1	- For State	Sta	ate of Mary	/land /	Depart Certii	ment of ficate of	Health an Death	d Menta	al Hygiene	Reg. N	20	119	2520
Dhygiois	E	Registrar 1. Decedent's Name	e (First, Middl	e,Last)						2, Date of D	eath		3. Time	
Physicia edical Exami				-,,						July 27,	2009	Year	1452	2 hrs
0 *		Mary R. 4a. Facility Name (i	<u>cavey</u> f not institutio	n, give street and	I number)		4	b. City, Town, or	Location of I	Death		4c. County of Dea	ith	
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death with the Maryland or items 23a or 28a-f show any must be notified at once.		15 Moor	isnerr		Oecedent	Ever in U.S.	13. Wa		ispanic Origin	n? ( Specify Yes or		14. Race - Am		an, Black,
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MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiers T's marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	T0	19a. Informant's N			)					ber or Rural Route				de)
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Division of Vital Records, pital or Attending Physician. The law requirements after death. After this certificate has been if filled in by the funeral director, page 2 should	Certification:	4 Homicide	3	17	ecify)									
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To the within 7	Medical	one) 2		and ma	nner state	ed.			ense number			29d. Date signed		
	Įź	29b. Signature a	nd title of cert	mer	) ^	Λ.			.C.M.E.			July 28, 2009	_ `	,
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 925 pm 02,2009 Mary F. Carroll ~9~1 t /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner De 61 urs (no 8. Date of Birth (Month, Day, Year) Nov 19, 1922 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days white 1□M 25 F 86 218-12-2656 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County r 28a-f show notified at 10a. State 1 ☐ Yes 2 No Harford Havre de Grace Director MD 10g Citizen of What Country? 10f. Zip Code 10e Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r USA 21078 415 S. Market Street Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 accountant financial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James William Fyle Blanche Loving Smith ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan Asher/daughter 813 Tydings Road Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∏Donation 5 ☐ Other (Specify) 21. Signature of Firmeral Struice Licensee Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) sekst Physician /Medical Due to (or as Examiner Secure tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 certificate has 1⊟ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Tyes 1 Inpatient Certification: To this Division or 28d. Describe how injury occurred 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Hospital or Attending 24 hours after death. Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 :- ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3 09 MID s of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

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32. Registrar's Signature

Month, Day, Year) AUG 07 2009 HD6

amend #30 Star of War farty & Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 15 A.M **Physician** 200 a 0 /Medical 4c. County of Death City, Town, or Location of Death a. Facility Name (If not institution, give street and number) 4b. Examiner COY uch spice of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 □ F Months Days Min. Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Modical Examination be notified at 1 ☐ Yes 2√∑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA ane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Z□ No 1 Yes Specify: þ 3 Widowed 4 Divorced Completed unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Its Mo Elementary/Secondary (0-12) College (1-4or 5+) 12 photographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Davidson Lawrence Campbell Margaret Lois Weber ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6402 Church hill Road Chestertown, MD Tina Cohey/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of meral Similar Lice State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) idnes months **Physician** /Medical Lue to (or as a consequence of): Examiner M6 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a sur sedue ree of) Examiner The law requires that the death certificate be executed 120 meta and burial-trar Due to (or as a consequence of): P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 nknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes Attending Physician: e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Tother (Specify) Hospice 2 **☑** No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗌 Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🛏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 005 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre Ste 200 Chestertown MD.21620 Chestertown Family Medicine Frederick William Delboy 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 07 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 47 AM DUBA AVG UST 2009 ELSIE 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTI MORE If Under 1 Year If Under 24 Hrs. JOHNS HEAKINS MEDICAL BAYVIGU none 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F Months Days Hours 80 Director 212-26-7586 01/25/1929 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evant are rust by retiffed at 1 □Yes 2XXNo Maryland Baltimore Middle River Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21220 U.S.A. 1711 Wilson Point Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐Yes 2X No Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2XXNo Specify Specify: White à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate Retail 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic evenues. Mary Monger Ralph Nichols ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1711 Wilson Point Road, Baltimore, Maryland 21220 Ronald Hornberger (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XX Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 08/11/2009 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A 21. Signature of Funeral Selvice Linux ee 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPS15 18 HOURS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of mjury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No ned by the 9 Unknown 9 Unknown signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 nknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled i 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.0.

State Registrar

31. Date filed (Month, Day, Year) 07 2009 AUG

29b. Signature and title of certifi

30. Name and a

4940 32. Registrar's Signature

and manner stated.

dress of person who completed cause of death (Item 23a) (Type, Print)

anke

within 2 To the I

29c. License number

EASTERN

KES-000

29d. Date signed (Month, Day, Year)

AVENUE BALTIMORE MD ZIZZY

AUGUST 6, 2009

09-06007 William Daly Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2009 25204

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ledical Examir		William		ison	Da1	У	14	b. City, To	wn orlo	cation of		August 1,		ounty of Dea	th
	•	4a. Facility Name (if not institut 7970 Waterloo Road		reet and nu	imber)		"	Jessur		roation or	Dodo			ward	_
F	_	5. Social Security Number	6. Sex		7. Age (in y	rs. last birt	hday)	If Under	1 Year	If Under	24Hrs. 8	B. Date of B	rth (MM/DD		irthplace (State or
Funeral Director				□ E			Yrs.	Months	Days	Hours	Min.	C +	9, 19	Fore	country) Maryland
Directo.		220-76-7421 Usual Residence of Decedent	1 X M	2F	51		115.	L	1			Sept	9, 19	75/	Haryrand
any	-	10a. State 10b. Count	/		10c.	City, Town	or Location	on							10d. Inside City Limits
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Maryland 28a-f show 1 at once,	용	Maryland Ann  10e. Street and Number	ie Al	under			9.0	10f. Zip (	Code			-	10g. Citizer	n of What Co	ountry?
or 28	Director	7810 Clark Ro	ad C	1 2				2	0794				Ur	nited	States
vith th		11. Marital Status		2. Was De	cedent Ever	in U.S.	13. Wa	s Deceden	t of Hisp	anic Origi	in? ( Spec	ify Yes or N	lo- 14	Race - Ame White, etc.	erican Indian, Black,
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X	Married	Armed F	orces?	No	" "	es, specify	cuban,	mexican,	Fuerto Ki	can, etc.)		Winto, Cto.	
ifter d	by F	3 Widowed 4	ivorced If	Yes, Give Ye				Yes 2		_					hite
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6 172 h an "n cal E	Completed	Elementary/Secondary (0-12	2)	College (	1-4 or 5+)			m	1				1	Cian	Company
within iene.	Ĕ.	9 17. Father's Name (First, Midd	la Last\				518	gn Te	cnn1	.can 8.Mother's	's Name (F	ırst, Middle	, Maiden Si		Company
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21215-0036 wald be filed within 7 Mental Hygiene. marked other than	o Be	Allan Do	incan nship (Typ		.ту	19	b. Mailing	g Address	(Street	and Num	ber or Ru	ral Route N	umber, City	or Town, Sta	ate, Zip Code)
Otabia	-	Dawn Marie Da				7	810	Cla <u>rk</u>	Roa	d C1	.8 J	essup	Mary	yland_	20794
and and lealth item	: 1	20a. Method of Disposition				20b. Place	of Dispos					Date	20c. Lo	ocation - City	or Town, State
Baltimore, MD 2's permit. Pages I and 2 should be permit. Pages I and 2 should Department of Health and Minportant: If item 27 is minjury or other traumatite.		1 Burial 2 X Cremat		Removal	from State	V Aru	-		ator	y	8/4	/2009	00	denton	, Maryland
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Baltimore, ME permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		Juanita R4	flome	26			114	11 An	napo	lis	Road	- Odei	nton,	Maryl	and 21113
Physician		23 Fart I. Enter the disease, failure, List only one cau	or complic	ations that	caused the o	teath. Do r	not enter t	he mode o	of dying,	such as c	ardiac or r	espiratory a	rrest, shoc	k, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disea	0.4	lultiple Ir	njuri <b>e</b> s										Death
xaminer		or condition resulting in death		ue to (or as	a conseque	nce of):									
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b	ue to /or as	a conseque	nce of):									
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x 61 h cert tendir use a	icia	past 12 months?		4 Pre	gnant at time	of death	5 O	ther (Spe	cify)						
Box te death of the atten	hys		Unknown		nown		- 11-			iven in D	ort I	23e Di	d tobacco u	ise contribute	e to the cause of death?
Records, P.O. Box 6  The law requires that the death cen cate has been signed by the attendi page 2 should be detached for use	by P	Part II. Other significant cor	ditions	contributing	to death but	not result	ing in the	underlying	y cause g	liveiriire	art i.				Probably 4 Unknown
S, D uires t n sign id be e		·										24a. W	as an	1 24b. Were	e autopsy findings available
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al Finanti ani dentifice ertifice ctor, p	Φ.	25. Was case referred to med examiner?	_	-			-		27	of Death Other	(Check o				N O
Vit hysici this o	To B	1 ✓ Yes 2 No	HC	ospital: 1	Inpatient		Outpatier		OOA Jaiu			Home 5		nce 6 🗹 C	oner: Scene
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rastler death the return After this certificate has been signed by led in by the funeral director, page 2 should be detact		27. Manner of Death  1 Natural 5		28a. Da (Mo	ite of Injury nth, Day,Year) , 2009		o. Time of 46 hrs	injury		ry at Wor	_ Ir	Driver au	to auto c	ollision	
ivisior  I or Attend  after death  Director:	aţi		ending nvestigation	n	ace of Injury	Athoma	form oth	not factor				28f Locatio	n (Street a	nd Number o	r Rural Route Number, City
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sspi hou mer y fill		4 Homicide		(-)	fy) Local		teath occ	urred at th	e time d	ate and n				d manner as	
To the Ile within 24 To the Fu	Medical	(Check only one) 2 Medical	Examiner:	On the bas	is of examina	ation and/o	r investig	ation, in m	y opinior	n, death o	occurred at	the time, d	ate and pla	ice, and due	to the cause(s)
Virth Com	Med	29b. Signature and title of ce		and manne	er stated			29	c. Licens	e numbe	er		29d. l	Date signed	(Month, Day, Year)
	-	61.	-	1 -	10	1	7		O.C.	M.E.			Aug	just 2, 200	09
		30. Name and address of pe	son w o c	ompleted c	ause of deat	h (Mem 23a	a)	1		-	_				
		Zabiullah Ali, M.D.		tant Met	dical Exar	niner	111 Pe	nn Stre	et, Bal	timore,	MD 212	201			
	tate	4449 - O E	ar) 119	12	Registraris :	Signature	year	Rus							
Regi				-		A 15 18	.00								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dudley Donovan Dietrick 4:10a M 6, 2009 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville Oak Crest Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. Months 1 XM 2 ☐ F 146-09-6628 86 06/06/1923 NJ Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventhal must be notified in once. 10a State Baltimore Parkville Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21234 8800 Walther Boulevard, Apt4510 USA Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Xes 2 □ No If Yes, Give Year or Dates: US Navy 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printing Printer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stone Carrie George Dietrick ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Boulevard, Apt. 4510, Parkville 21234 19a. Informant's Name/Relationship (Type. Print)
Shirley Dietrick Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/7/2009 Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services Marchal Po Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 76 **Physician** /Medical Due to (or as a consequence Examiner Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide PRACTITIONEK 12 Certifying Physiciam: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie R04358D reis chr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTHER RE 8830 BLUD- BALTO MI 2. Registrar's Signature 31. Date filed (Month, Day, Year) State **AUG 07** Registrar

09-06013 Ju

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

dy Davis		State of Maryland / Department of I  For State Certificate of I	Health and Mental Hy De <i>ath</i>	giene Reg. N	2009 25
Physician edical Examine	/ 1	egistrar Decedent's Name (First, Middle,Last) Judy Davis		2. Date of Death Month Da August 1, 200	3. Time of Death
euicai Examme		ia. Facility Name (if not institution, give street and number)  4b	D. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel
Funeral Director	5	5. Social Security Number 2 1 9 - 4 0 - 9 7 8 0 6. Sex 7. Age (In xrs_last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	8. Date of Birth (N	MM/DD/YYYY) 9. Birthplace (State or For Country) MD
auy		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Anne Arunde1	Pasadena		10d. Inside City Lin
the Maryland a or 28a-f show	<u> </u>		10f. Zip Code	10g.	Citizen of What Country?
with the Maryland s 23a or 28a-f sho			21122  Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
fter death with 1", or items 23 ter must be no		Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1	s, specify Cuban, Mexican, Puerto Yes 2 X No specify:		White Specify:
5-0036 ed within 72 hours after bygiene. other than "natural", the Medical Examiner	leted by	15 Decedent's Education (Specify only highest grade completed) 16a. Decedent'	s Usual Occupation (Give kind of w st of working life. DO NOT use retin Artist		Freelance
	<b>ગ</b>	17. Father's Name (First, Middle, Last) John Craig	18.Mother's Name Gene		
imore, MD 2121 Pages I and 2 should be finent of Health and Mental and: If item 27 is marked or other traumatic eveut,	10 26	10 Information Name (Relationship (Tupo Print)) 19h Mailing	Address (Street and Number or F Rogers Avenue	Rural Route Numbe	er, City or Town, State, Zip Code) cott City, MD 2
iore, MD 2 ges 1 and 2 shoul t of Health and M :: If item 27 is n other traumatic	ŀ	20a. Method of Disposition  1 Burial 2 XCremation 3 Removal from State a rematory or oth Ardent	tion (Name of cemetery, er place) Crematory 8/	Date 2 5/2009	Coc. Location - City or Town, State Hanover, MD
Baltimore, permit. Pages I a Department of He Important: If He injury or other ti		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Dorota Marshall 22. N	ame and Address of Facility Mary Land Crema	ation So	ervices
Physician /Medical		23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the	Car ton Cramado		mvaramines
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Propoxyphene, Amitrip Due to (or as a consequence of): Hydroc	odone, Codeine,	Morphine	) and Asphyxia
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and - tra	al Exa	events resulting in death) Last	perME, g894 8/2	4/09 TT	
Box 68760, e death certificate be ex the attending physician ed for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Fellowship 1 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 2 Live birth 3 Live birth	tal death 3 Ectopic pregnate her (Specify)	ancy	23d. Date of delivery  Month Day Year
ires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.		acco use contribute to the cause of death  2 No 3 Probably 4 Unknown
y requ	Completed			24a. Was ar autopsy perform 1 Yes 2	prior to completion of cause death?
Vital Recc ysician: The lar his certificate ha director, page 2	ă B	25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient	26.Place of Death (Check		esidence 6 🗸 Other: Scene
n of Vil	on: To	1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Death  1 Natural 5 Death  28a. Date of Injury (Month, Day, Year)  28b. Time of I	injury 28c. injury at Work?	28d. Describe ho ingested found wi	winjury.occurred Subject Medications and w th plastic bag on
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident Investigation 3 X Suicide 6 Could not be determined determined (Specific) house		head 28f. Location (St or Town, Sta Pasadena	reet and Number or Rural Route Number ate) 8246 Miramar Rd
To the Hospital within 24 hours To the Funeral completely filled	Medical Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur one) Certifying Physician: To the best of my knowledge, death occur one) Medical Examiner:On the basis of examination and/or investigation.	rred at the time, date and place, an tion, in my opinion, death occurred	d due to the cause at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
S E E E E	Med	29b. Signature and title of certifier  Annual Fauthau MA	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 2, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 11	11 Penn Street, Baltimore,	MD 21201	
Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	V.1		
Registi DHMH 17 Rev 1/20		ORIGINA	AL.		

			1 - State of Maryland / Department Certification	te of Death		g. No. 2009	25207
П	Physici	an	1. Decedent's Name (First, Middle, Last)  James Joseph Demarest Sr.		2. Date of Death Month August	Day Year	3. Time of Death 10:45 a M
-	/Medio Examir		4a. Facility Name (If not institution, give street and number)  4b. City	, Town, or Location of Death	August	4c. County of Death	10:45
-	Funeral		1451 Towson Street  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde	Baltimore or 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		090-22-2489	Days Hours Min.	8. Date of Birth (Month, Day, 07/15/1	929 Coul	NY
	iryland show	<u>_</u>	10a. State 10b. County 10c. City, Town or Location	altimore			10d. Inside City Limits
	the Ma 28a-f s	recto		p Code	10	og. Citizen of What Cou	1 Mes 2 No
	ath with 23a or ust be	ral Di		21230		USA	
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evar institute be nutified at once.	d by Funeral Director	1 □ Never Married 2 ☑ Married   1 ☑ Yes 2 □ No. U.S. A1 miv	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2X No Specify:			etc. nite
21215-0036	i within 72 h jiene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 12  College (1-4or 5+) College (1-4or 5+)	ual Occupation ork done during most of work use retired) e worker	ing   1	6b. Kind of Business/In Baltimore ( Electri	as And
Maryland 2	uld be filed Mental Hyg srked other	To Be C	17. Father's Name (First, Middle, Last) Robert S. Demarest. SR	18. Mother's Name		,	
	and 2 sho salth and n 27 is me er traume		Mary E. Demarest / Wife 19b. Mailing Addres 1451 Tow	s (Street and Number or Rur son Street, B	al Route Number, altimore	City or Town, State, Zip, MD 21230	o Code)
Baltimore,	t. Pages 1. rtment of He rtant: If iten		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Nacemetery, crematory or Glen Haven Celemontal Celemont State Ce	metery 8/8/		Oc. Location - City or To Glen Burnie	
Bal	permi Depar Impor any ir		Char	nd Address of Facility les L. Steven: Fast Fort Av			
N. Y.	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	de of dying, such as cardiac	or respiratory arre	sst,	Approximate Interval Between Onset and Death
	ted sit	Examiner	Sequentially list conditions, if any, is adding to the conditions.  Lucause. Enter Underlying Cause (Disease or injury that initiated events  c.				
68760,	tificate be executed ig physician and as the burial-transit	ledical Exan	that initiated events resulting in death) Last   C. Due to (or as a consequence of):  d.				
P.O. Box 6	attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic   5   Other (s			23d. Date of deliv Month	ery Day Year
Records, F	equires that sen signed b	ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying.	cause given in Part I.		acco use contribute to to s s 2 ☐ No 3 ☐ Pro	he cause of death?
al Reco		Completed by			24a. Was an autopsy perform 1 □Yes 2	prior to co death? No 1 Yes	opsy findings available impletion of cause of
f Vit	Physician: this certific ral director,	ro Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D	OA Other: 4 Nursing Ho		nce 6 □Other <i>(Speci</i>	fy)
o uc	ding Pt h. After th funeral	ion:	11		28d. Describe how		
Division of Vital	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)		28f. Location (Str City or Town,	eet and Number or Run State)	al Route Number,
}	he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifler (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.	d at the time, date and place, n, in my opinion, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due t	stated. o the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifler  ACC SIGNATURE AND THE PROPERTY OF THE P	C. License number	29	od. Date signed (Month,	Day, Year)
			30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  AFROZE MUNEER GOLE.	Fort au	le Bo	alkina	MDS123
	Sta Registr		31. Date filed (Month, Day, Year)  22. Registrar's Signature  AUG 0 17 2009  August B. Sawki				

DHMH 17 Rev 1/2001

09-06044 Stanley Dalton

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turnoy Banon		1- For State Critical State of Waliyiand / Departific	ate of Death		2 U U S	2020
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death     Month	Day Year	3. Time of Death 0732 hrs
Nedical Examin		Stanley Dalton  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of	August 3, 2	4c. County of Death	0732 1115
7		3829 South Hanover Street	Brooklyn	Doddi	lor goonly or Doolly	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bird			(MM/DD/YYYY) 9. Birth Foreign	pplace (State or
Director		225-40-0143   1XM 2 F   76	Yrs. Months Days Hours	Apr 8,	1933 Cou	ntry. Virginia
Š.	ļ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
ow any		MD Broc	klyn imore			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	Λ
72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Ex-miner must be notified at once	嵩	3829 S. hanover Street	21225		USA	
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F		14. Race - Americ White, etc.	an Indian, Black,
er deat	[]	1 Never Married 2 Married 1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 51-55	1 Yes 2 No specify:	,	Specify:	
urs afte tural",	좕	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kir		16b. Kind of Business/Ir	
5-0036 led within 72 hours at Hygiene. I other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT us	se retired)		
15-0036 filed within all Hygiene. ed other that t, the Medic	E L	12 0	chef	Name (First, Middle, M	food indus	stry
filed wit al Hygien ed other	Be C	17. Father's Name (First, Middle, Last) William Lawson Dalton			aiden Surname)	
c a ge s			b. Mailing Address (Street and Numb	th Surratt er or Rural Route Numb	per, City or Town, State,	Zip Code)
MD d 2 sho lth and n 27 is	1	Wayne Dalton/brother 7	755 Church Street of Disposition (Name of cemetery,	Middletown	VA 2264	15
it de a		20a. Method of Disposition  20b. Place  Removal from State  20b. Place  cremat	of Disposition (Name of cemetery, tory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donation 5 X Other Specify: in state Metropo	litan Crematory	8/12/09	Alexandria,	VA
Baltimore permit. Pages 1 Department of 1 Important: If		21. Signature of Fineral Service licensee Konald S. Wady, Director	22. Name and Address of Facilit M	mar 1 GEE ti	The Tardenson of	C A
Physician	$\dashv$	23a. Pan I. Enter the disease, or complications that caused the death. Do no	ot enter the mode of dying, such as car	diac or respiratory arre	st, shock, or heart	Approximate Interval
/ /Medical		failule. List only one cause on each line.  Immediate Cause (Final disease a, Atherosclerotic Cardiovascu	ılar Disease			Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):				
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			3	
rted d ansit	Exa	events resulting in death) Last Due to (or as a consequence or):  d.				
e executed tian and ial - trans	Medical	UNPENDED		·		
760, icate be executed physician and the burial - transit		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
Sox 687 leath certifi e attending for use as t	cian	past 12 Hollins:	Fetal death 3 Ectopic p  Other (Specify)	pregnancy	Month D	ay Year
Box 687 e death certification attending	Physician	1 Yes 2 No 9 Unknown 9 Unknown	O Cities (opeany)			
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physiciately filled in by the funeral director, page 2 should be detached for use as the buring the funeral director, page 2 should be detached for use as the buring.	by PI	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part		pacco use contribute to t	
S, P	ed			24a. Was a		opsy findings available
cords, Flaw requires has been sig 2 should be	Completed		<u> </u>	autops perforr	y prior to c	ompletion of cause of
tal Reco	틼	OF Was area of a sud to modical	26.Place of Death (C		No 1 Ye	s 2 No
Vital F ysician: his certifi	B	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/C	10thor:		Residence 6 🗸 Other	: Scene
n of V ding Phy L. After th funeral c	٦	27. Manner of Death  28a. Date of Injury  (Month, Day, Year)	Time of Injury 28c. Injury at Work?	28d. Describe h	ow injury occurred	***
ion tendir leath.	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2	No		
Division of Vital Records, tal or Attending Physician: The law requin rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, f	farm, street, factory, office building, etc.	28f. Location (S or Town, St	treet and Number or Rui ate)	ral Route Number, City
Di Ospital hours a uneral I		29a. Certifier	ath accurred at the time, date and place	e and due to the cause	a(s) and manner as state	ad .
To the Howithin 24 h To the Fun completely	Medical	(Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	urred at the time, date a	and place, and due to the	e cause(s)
	Š	29b. Signature and title of certifier	29c. License number	-	29d. Date signed (Mor	nth, Day, Year)
		ane 2	O.C.M.E.		August 4, 2009	
	Ì	30. Name and address of person who completed cause of death (Item 23a)	Ponn Street Politimera MD 5	21201		
		22 Posistraria Cianatura	Penn Street, Baltimore, MD 2			
Regist	ate rar		Acres de			
DHMH 17 Rev 1/20	001	of	RIGINAL	. oc	ME	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		_	For State Registrar			iryiand /		rtment of F				Reg. No.	2009	25209	
	Physicia		Decedent's Name (First, Middle, Last)  WAYNE LEE EADER								2. Date of De Month August	Day	Year 2009	3. Time of Death  3:35 a M	
	/Medic Examin									of Death					
فاستد			Holy Cros		Silver If Under 1 Year		ing er 24 Hrs.	8. Date of Bir		Montgom	-				
	Funeral Director		5. Social Security Nu 218-38-73	363	ox 7. Age X 2 F 7. Age	66	Yrs.	Months Days	Hours		(Month, Da Mar • 2	ay, Year)	9. Birthplace (State or Foreign Country) 1943 Maryland		
	and w		Usual Residence of 10a. State	10b. County		10c. City, To	wn or Lo	cation	_					10d. Inside City Limits	
	Mary t-f sh	tor	MD	Montgom	ery	SIl	ver	Spring						1 ☐ Yes 2 ☐ No	
	or 28%	Director	10e. Street and Num	ber				10f. Zip Code		1,11		10g. Citi:	zen of What Co	untry?	
	23a c		3032 Wini	fred Dri				20866					S.A.		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Event in a must be notified a once.	by Funeral	11. Marital Status  1 ☐ Never Marrie  3 ☒ Widowed		12. Was Decedent E Armed Forces? 1 □ Yes 2 XX If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba 1 □Yes 2 <b>XIX</b> Io	lispanic C an, Mexic Specif		ecify Yes or No Rican, etc.)		14. Race - Ame Black, White Specify: Whi	, etc.	
9	2 hou	ted		15. Decedent's Education					ation	set of work	ina		nd of Business/l		
21215-0036	ithin 7. ne. han "n	Completed		(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  Grade 12					(Give kind of work done during most of workir life. DO NOT use retired)  Truck Driver					vina	
2	iled w Hygie Ither tl			17. Father's Name (First, Middle, Last)						her's Name	(First, Middle		halt Pa Surname)	VIIIG	
ano	d be f ental ked o	o Be	Herman Ea						Glo	ria A	they				
ar y	shoul	은	19a. Informant's Na		Type. Print)	11	9b. Mailir	ng Address (Street	and Num	ber or Rur	al Route Numb	er, City o	r Town, State, 2	Zip Code)	
ž	and 2 salth a n 27 is er tra		David Lee	e Eader	/ son		313	Marganza	s.	Laur	el, Mar	ylan	d 2072	4	
ore	es 1 s of He if item		20a. Method of Disp		Removal from State	20b. Place ceme	of Dispo tery, cren	sition (Name of natory or other plac	ce)	[	Date	20c. Lo	cation - City or	Town, State	
Ĕ	Pag tment tant: I			5 Other (Specify		West		del Crem		8/6/			enton,	Maryland	
Baltimore, Maryland	permit Depar Impor any in		21. Signature of Fur	SKY	M	22. Name and Address of Facility Donaldson Funeral Home, P.A.  M00770 313 Talbott Avenue Laurel, Maryla							aryland	20707	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death											Interval Retween	
المرا	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Cardiac Arrest												
	/Medical Examiner		resulting in death)	•	Due to (or as a	-		mi a							
		er	Sequentially list con	nditions,	al Arr aconsequenc		шита								
	cuted id ansit	Examiner	cause. Enter Under Cause (Disease or i that initiated events	stive H	leart	Failure									
Ö,	ificate be executed g physician and as the burial-transit	I Ex	resulting in death) Last  Due to (or as a consequence of):												
68760,	cate to physic the p	edical			d										
O. Box 6	ath certi ttending or use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)										23d. Date of delivery Month Day Year		
σ.	uires that the de signed by the a d be detached f			icant conditions	ontributing to death bu	ut not resulting	g in the u	nderlying cause giv	en in Par	t I.	23e. Did	23e. Did tobacco use contribute to the cause of death			
rds	quires an sign uld be	ed by									1 🗆	Yes 2	□ No 3□ P	robably 4XXInknown	
9 0 0	aw requir as been s 2 should	plete									24a. Was		24b. Were au	utopsy findings available completion of cause of	
24a. Was an autopsy perform the property of th								ormed?	death?	2 <b>)(</b> )(0					
/ita	clan: ertific ector,	Be (	25. Was case referr examiner?	red to medical	11			T 044		ice of Deat	h (Check only	one)			
of	Physical direct		1 ☐ Yes 2XX			nt 2 ☐ ER/		III 3 LI DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)  njury at 28d. Describe how injury occurred					ecify)	
O	Attending ir death. ector: After by the funer	tion	1 KTX atural 5 □ Pending (Month, Day, Year)   Injury   W							□No			,		
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	Solution   Street   Solution   Solution   Street   Solution   S								(Street ar. own, State	reet and Number or Rural Route Number, o, State)			
/	the Hospital or hin 24 hours afte the Funeral Dira mpletely filled in I	Medical C	29a. Certifier (Check only one)		nysician: To the best opiner: On the basis of and manner sta	f examination									
7	To the within 2 To the comple	Me	29b. Signature and	title of certifier		//	M	29c. Licens	se numbe	er		29d. Da	te signed (Moni	th, Day, Year)	
			1	M///	1	1			6758	9		Aug	ust 4,	2009	
			30. Name and address		. //	eath (Item 23			n D-	24 0	ilvon (	Invir	C MD	20910	
	- Ch	<b>.</b>		Vincent I				rest Gle	II KO	au S	ilver S	P T T U	A, MD	20910	
	Sta Registr		31. Date filed (Mont	U 7 2009	Deneur	ar's Signature	100 M	2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** ELANAGAN AUGUST 2009 DEODGIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CENTELI MEDICAL If Under 1 Year If Under 24 Hrs. BALTIM HOPKINS BAYVIEW JOHNS 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 02/05/1925 1 □ M 2 🕱 F 84 214-20-3434 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evan in the motified at 1 ☐Yes 2X No Director Baltimore Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with U.S.A. 21224 7854 Wynbrook Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 □Yes 2 No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White ⋧ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Marion Dale Kistler George Gilmore Pyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daniel Patrick Flanagan (Husband) 7854 Wynbrook Road, Baltimore, Maryland 21224 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/10/2009 | Baltimore, Maryland Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryalnd 21221 21. Signature of Funeral Service Livenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Interval Between Onset and Death Immedia ause (Final disea or condition resulting in death) Physician MYOCARDIAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, physician attending pl IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 sl autopsy performed? certificate | 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ★ ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at After 1 Natural 5 Pending investigation n 24 hours after death.

In Funeral Director: Af olderely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4 glass Bayerew redical Conter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

MD

32. Registrar's Signature

			For State Registrar		State of	Marylan	•	artmen rtificat			and M		giene Reg. No.		20	25011
	Physicia	ın	1. Decedent's Nam	•	<sub>ast)</sub> Filbert							2. Date of Dea Month August	ath Day	<del>Z U t</del>	ear /	3. Time of Death 5:20 A M
Ô	/Medic Examin		4a. Facility Name (	If not institution, gi		nber)			Town, or	Location o	of Death	August	4c.	County of		
	Funeral Director		5. Social Security N 220-52-4	7. Age (In yrs. 61	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 12/10/	1947	9. Birthplace (State or Fo. Country) 47 Maryland				
	/aryland f show	or	Usual Residence o 10a. State MD	10b. County Baltimo	re		y, Town or Lo		-						10	0d. tnside City Limits 1 ☐ Yes 2 🕱 No
	with the Na or 28a-	Funeral Director	10e. Street and Nu		Road			10f. Zip	Code					izen of Wh	at Coun	ry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be rediffied at once.	by Funera	11. Marital Status	ried 2□ Married	12. Was Dece Armed For 1 1 Yes If Yes, Giv	2 □ No ⁄e			dent of Hi cify Cuba	spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		14. Race -	White, e	tc.
:20 а.m. 21215-0036	hin 72 hours e. an "natural"	Completed b		15. Decedent's E cify only highest g	rade completed)			kind of wo DO NOT u	al Occupa ork done o se retired	ation furing mos	t of worki	ing		ind of Busi		
5:20 and 212	the filed with the filed with the filed other the sevent, the	Be	17. Father's Name				Engi	neer				(First, Middle,	Maiden	Surname)		
2009 5 Maryland	nd 2 should lith and Me 27 is mark r traumation	<u>م</u>	Howard 19a. Informant's N Richard	lame/Relationship			_	_		and Numb	er or Run	al Route Numb uthervi	er, City o	or Town, S		
UGUST 6, Baltimore,	Pages 1 ar nent of Hea ant: if item ury or othe		20a. Method of Dis		☐ Removal from \$	20b. F	Place of Disponentery, cremetery, cremetery	osition (Na matory or o	me of other plac	e)		Date /2009	20c. L	ocation - C	ity or To	wn, State Maryland
AUGUST   Baltim	permit. Departr Importa any inji		XXX	uneral Service Lic	Me .	,	Ru		owson	Fune	eral	Towson, Home,	Inc.			^k Road
	Physician		Speck or heart failure. List only one cause on each line											Approximate Interval Between Onset and Death		
	/Medical Examiner	er		- 1	Due to (or as a consequence of):  Due to (or as a consequence of):											
<sup>l</sup> √ ,09	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate sause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Cc. Due to (or as a consequence of):													
Box 68760	ath certifi attending for use as	by Physician/Medical	IF FEMALE: 23b. Was deceded in the past 12 1 □ Yes 2	2 months?	1 ☐ Live I 4 ☐ Pregi	come of pregnations of the come of com	al déath 3[	⊒ Ectopic ⊒ Other (s		у				23d. Date Mont		ery Day Year
FILBERT rds, P.O.	s that the c gned by the re detached	y Physi	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did t	23e. Did tobacco use contribute to the cause of death?				
DAVID FIL Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Completed b									24a. Was	1   Yes 2   No 3   Probably 4   Unknown  24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?				
DA Vital F	Physician: Th r this certificate ral director, pag	Be	25. Was case reference examiner?		Hospital:		lene		OA Othe			1 ☐ Yes h (Check only o	2 ሺ No one)	1[	□Yes	
Division of	Attending Physic death. ector: After this by the funeral di	Certification: To	1  Yes 2	5 ☐ Pending investigati	28a. Date (Mon	28a. Date of Injury (Month, Day, Year)  2 □ ER/Outpatient 3 □ DOA □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □				tome 5 ☐ Residence 6  Other (Specify) HOSPICE  28d. Describe how injury occurred						
Divis	ital or Atteurs after de rai Directo															
M	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) X N 29b. Signature and	2□ Medical Ex urse Pra	aminer: On the b	asis of examina	owledge, dea ation and/or it	nvestigatio	n, in my c	me, date a opinion, de ————— e number	ath occur	and due to the	, date an	nd place, ar	nd due to	the cause(s)
07	To To	~	1	MINE	MAR	, , , , , , ,	- 00 \ (=	1	R14°	979	2		29d. Date signed (Month, Day, Year)			9
	Sta	to.	JACKIE 31. Date filed (Mo	JONES, C	₫2. F	se of death (Itel <b>)0 DULA</b> Registrar's Sign	NEY VA		RD.	TIMO	NIUM	, MD 21	L <b>093</b>			
	Registr		ΔΙ	IG 0.7 201	19 Steres	m B	. Alle	A STATE OF THE STA								

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3. Time of Death

Birthplace (State or Foreign Country)

10d Inside City Limits

Approximate Interval Between Onset and Death

Year

2 🗆 No

29d. Date signed (Month, Day, Year)

1XYes 2 □ No

MD

8:04PM

To the Hospital of within 24 hours at To the Funeral D 3

filled in by

4 Homicide

29b. Signature and title of certifier

RYAN

31. Date filed (Month, Day, Year)

29a, Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

Greene

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

ST

A41476435N18873

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

, M.D.

S

Barka

22

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOWAK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

			For State Registrar	State of Ma	aryland	/ Depa	rtment of F	lealth and Death	d Mental H	ygienę́ Reg. No.	2009	252	13	
T	Physici	an	Decedent's Name (First, Middle,			2. Date of E Month	eath	h 3. Time of Death						
	/Medic	cal	Rathingra Nath Gnoshtagore								2009 County of Deat	4:45	A M	
	Examin	ier	Fairland Nursing Home Silve						au.		Montgomery			
	Funeral			6. Sex 7. Age	e (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 H	frs. 8. Date of E (Month, I		9. Birt	hplace (State o	r Foreign	
	Director		017-36-4968	1 X M 2 □ F	72	Yrs.	Wichitis Days	i iodis ivi	08-14	-1938		nglades	h	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside Ci	ty Limits	
	Mary a-f sh	tor	MD Howa	rd			Co	lumbia				1 □ Yes	2 X No	
	or 28	Direc	10e. Street and Number		J.		10f. Zip Code			10g. Citi:	zen of What Co	untry?		
	ath wi	Funeral Director	5210 Lightfoot	Path				1044			ited St	ates		
	items	une	11. Marital Status	12. Was Decedent B Armed Forces? 1 □ Yes 2 📉 N		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	lo-	<ol> <li>Race - Ame Black, White</li> </ol>			
USO D	urs aft	þ	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:	WO .	1	□Yes 2 <b>X</b> No	Specify:			Specify: As	ian Ind	ian	
0500-c1	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it is Medical Exp. it arts ust be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working							16b. Kir	nd of Business/		1411	
7	/ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5+)											
N	illed w Hygie ther t		17. Father's Name (First, Middle, L	5+		Mater	ial Scie		ineer lame (First, Midd)		iconduc	tor Dev	rices	
and	ld be tental ked o	To Be	Rabindra Nath		٠.				oka Basu	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, its Medical Exp. it art, ust be notified all once.	-	19a. Informant's Name/Relationshi			19b. Mailin	g Address (Street			ber, City o	r Town, State, 2	Zip Code)		
Ξ.	and 2 ealth n 27 i		Ujjal Kumar Gho	shtagore /	Son		Garfias		Pasadena					
o e	ges 1 It of H If iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	3 ☐ Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other plac	ce)	Date	20c. Lo	cation - City or	Town, State		
Dallimol	it. Pagirtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Sp.	ecify)	W. A		1 Cremat		07-2009	00	enton,	Marylar	ıd	
מ	Depa Impo any I		21. Signature of Funeral Signature of Europe	Callu	Alu	S 22	Name and Addre Donaldso 1411 Ann	n Funer	al Home Road Ode	& Cre	matory Maryla	P.A. and 2113	13	
			23a. Part 1. Enter the disease, or of shock, or heart failure. List of	omplications that caused nly one cause on each lir	Athe death, ne.	Do not ente	er the mode of dyir	ng, such as card	diac or respiratory	arrest,		Approximate Interval Bet Onset and I	een	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	-		ithy - Ca	rdio-Re	spirator	y Fai	lure		, Cati	
	Examiner		, account,	Due to (or as	-		عدداداده				- 4			
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	scuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Chronic	Respi	irator	y Failur	е						
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700	ificate be executed physician and is the burial-transit	edical		d. Chronie	UDSTI	cuctiv	re Pulmon	ary Dis	ease					
Š	h certi ending use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance		le			2	23d. Date of del	ivery		
0	e death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnanc Other (specify) _	у			Month	Day Y	<b>/e</b> ar	
Ľ	nat the d by tl etach	Phy	9 Unknown			( Ab	destate a constant	and to Panel	OOn Die	I tabassa	aa aantellusta ta	. Also pourse of d	a oth 2	
olds,	ires the signeral signeral laberal	δ	Part II. Other significant condition		Yes 2	use contribute to the cause of death?  ☐ No 3 ☐ Probably 4 ☑ Unknown								
5	v requ	etec							-	nin e		- 1		
ב כ	he lav e has age 2:	Completed							– 24a. Wa – aut per	opsy formed?	prior to death?	topsy findings a completion of ca	ause of	
0	an: T	a)	25. Was case referred to medical					26. Place of F	1 □Yes Death (Check only		1 ∐Yes	2 □No		
>	nysici nis cer direc	To B	examiner? 1 ☐ Yes 2 👿 No	Hospital: 1 ☐ Inpatie	ent 2 🗆 EF	R/Outpatien	t 3 □ DOA Oth	or:	g Home 5 ☐ Re		3 ☐ Other (Spe	cify)		
5	ing Pt Viter th	on:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry 21 y, Year)	8b. Time of Injury	28c. Injur Worl		28d. Describe	how injury	y occurred			
2	ttendi death. stor: / the fu	icati	2 Accident investigated investigated Accident investigated investigated Accident Accident A	ation	uru. At home	o form atre		Yes 2 □No	OR Lagation	(Ct at - a	d M	und Davida Mirror		
2	after after Direc d in by	Certification:	4 ☐ Homicide determin	et, lactory, office	et, factory, office 28f. Location (Stree City or Town, S			eet and Number or Rural Route Number, State)						
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier (Check only one)  1 ☑ CertifyIng 2 ☐ Medical E	Physician: To the best of the property of the pasts of the pasts of and manner sta	f examinatio	edge, death on and/or inv	occurred at the tile restigation, in my co	me, date and pla opinion, death o	ace, and due to the courred at the time	ne cause(s) e, date and	and manner as place, and due	s stated, to the cause(s	)	
/	Voithin Comp	Me	29b. Signature and title of certifier	m mil	)		29c. Licens	e number		29d. Dat	e signed (Mont	h, Day, Year)		
)			P ( X° . T.	me 2			D63	3232			8/5/00			
•			30. Name and address of person w	ho completed cause of de	eath (Item 2	3a) (Type, F	Print)	R. RO.	# 208 h	OKV)	ive, or	m 208	50	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	re	1000	0 1-0	., ., .,					
	Registr		AUG 07 20	the completed cause of do	A.	par	Kal							
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DHMH 17 Rev 1/2001

			For State Registrar	State of	Marylan		artment of H <i>rtificate of L</i>			giene Reg. No.	9	25214	
	Physicia		1. Decedent's Name (First, Middle, Last)  Gladys Mamie	Beal	l Gibso	n			2. Date of Dea Month August		.009	3. Time of Death 4:45pm м	
	/Medic Examin		4a. Facility Name (If not institution, give s.				4b. City, Town, or	Location of Dea		4c. County of Death			
			Fairhaven Health				Sykesy				Carrol1		
	Funeral Director		5. Social Security Number 6. Sex 1 $\square$	M 25F	7. Age (In yrs. : <b>97</b>	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Year) 1911	9. Birthp Cour	place (State or Foreign MD	
	D		Usual Residence of Decedent										
	arylar show	'n	10a. State 10b. County		10c. Cit	y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
5-0036 72 hours after death with the Maryland	the M	Director	MD Carrol  10e. Street and Number	1			10f. Zip Code	sville		10a. Citizen of V	ng. Citizen of What Country?		
	3a or	al Di	7200 Third Avenue				21784			USA			
	ems 2	Funeral		2. Was Deced	dent Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Rac	e - Americ	can Indian, etc.	
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Married 1 □Yes 2 TNNo If Yes Give X			1 □Yes 2√√ No	Specify:	,	Specify			
2-0036	s 1 and 2 should be thed within 72 hours after death with the Marylan f Health and Mental Hygiene. If Health and Mental Hygiene flem 271 is marked other than "natural" or frems 23a or 28a-f show other traumatic event, it a Modical Evan in the multiple indifferent and in the modifier of the modifierent traumatic event, it a Modical Evan in the modifierent traumatic event, it a Modical Evan in the modifierent traumatic event, it a Modical Evan in the modifierent traumatic event, it a Modical Evan in the modifierent traumatic event, it and it is a modifierent traumatic event, it is modical Evan in the modical Evan in the modifierent traumatic event, it is modifiered to the modifierent traumatic event, it is modifiered to the modifiered traumatic event.	ted t	15. Decedent's Educi		ites.	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	ısiness/Inc	dustry	
<del>داد</del>	thin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-	-4or 5+)	life.	kind of work done of DO NOT use retired	)	rorking				
2	filed within Hygiene. other than " ent, it e Ne	Cou	11	TOTOPHONE OFFICE							nications		
anc	ould be ti Mental I- arked ot atic ever	Be c	17. Father's Name (First, Middle, Last)  Trustin Day  18. Mother's Name (First, Middle, Maiden Surname, Eleanor Talbert								(6)		
<u></u>	should and Mer s marke umatic	<b>₽</b>	19a. Informant's Name/Relationship (Typ	e. Print)		19b. Maili	ng Address (Street			er, City or Town,	State, Zip	Code)	
	and 2 ealth a n 27 is ner tra		Mrs. Vera M. Stewa	rt (Ni			Fox Den		licott Ci				
Ψ			20a. Method of Disposition 1	moval from S			osition (Name of matory or other plac		Date	20c. Location -	•		
			4 Donation 5 Other (Specify)		Sp		ield Cemet			Sykesvi		MD	
g	permit. Departr imports any inj		21. Signature of Funeral Service License	rust	L MOD		AATGHT AFUI PO BOX 195				A .		
F	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that ca	aused the deat	- ' ' '						Approximate Interval Between Onset and Death	
0	Medical be executed by Medical by Medical and by Medical and sthe purish-transit	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (d	o as a consequence or a consequence or a conseq	Yasuuence of).	2 Car	diop	10 path	ð		months	
. Box	death certifications as death use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1  Sectopic pregnancy  1  Other (specify)  23d. Date of d  Month									ery Day Year	
ກຸ	iaw requires that the of as been signed by the 2 should be detached	by PI	Part II. Other significant conditions conf	ributing to de	ath but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use cont		he cause of death?	
ord G	equire een si	ted	atherosclerotic Cardio Vugala dis aue 24a. Was an								No 3 Probably 4 Unknown		
י בי	ine la ate has page 2	Completed	_atherosclero	ni	Cord	v DVa	salo o		perfor	rmed? 2 Salo	Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of 2 No	
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0	aing Pnys n. After this funeral di	n: To	27. Manner of Death	28a. Date o	of Injury	28b. Time of Injury	of 28c. Injur	y at	Home 5 Resid	ow injury occur		<u>y)</u>	
010	death. ctor: Aft y the fun	atio	Natural 5 Pending investigation	(MONU	h, Day, Year)	injury	M 1 🗆	Yes 2 □No					
DIVISION	or Atter frer de directo	Certification:	3 Suicide 6 Could not be determined	28e. Place buildir	of Injury - At hong, etc. (Specif	ome, farm, st fy)	reet, factory, office		28f. Location (5 City or Tow	Street and Numb n, State)	er or Rura	al Route Number,	
To the Hospital or Attenwithin 24 hours after death	lo the Hospital of Attentivition 24 hours after deat To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  29a. Certifying Phys  2 Medical Examin		asis of examina								
	vithin To the	Me	29b. Signature and little discertifier	>			29c. Licens	e number -184	7	29d. Date signe	d (Month,	Day, Year)	
	5		30. Name and address of person who con	npleted cause	e of death (Item	n 23a) (Type,	Serta T	3 45	2 Idens b	uz n	11)	2009	

State Registrar 31. Date filed (Month, Day, Year)

AIIC 07 2009

32. Registrar's Signature failes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 35 A M ARRISON **Physician** ARLOTT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner BALTIMIRE tOSPITAL NA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Country) **Funeral** Days Months 1 ☐ M 2 ☐XF 86 214-12-8354 Vrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show idical Exeminer must be notified at 1 Yes 2 □ No Director MD Na Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2008 Rayner Avenue 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. A f Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) African 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: American 3 ₩idowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Wedcal 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4or 5+) C&P Telephone Co. Short Order Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Walter Green Wallace Marylee မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1811 Ramblewood Road Baltimore, MD 21239 Brenda Jones-Daughter item 27 20c. Location - City or Town, State 20a. Method of Disposition

✓ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If it any Injury or o 08-10-09 |Baltimore, MD Druidridge Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Wylie Funeral Rome F.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death r-CtR Immediate Cause (Final Mu-ins **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expense. Due to for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 HInknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2, No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2 🚉 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated

PLACE

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Physician Month Year 4:25 a. M Go1dman August 5, Rosalvn Chassman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Pay, ) Feb. 10, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 √ F 1929 Michigan 381-22-7065 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County MD Montgomery Silver Spring 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 United States 8505 Springvale Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: <u>ک</u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Viola Jaffe Gerald L. Chassman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9311 Woodland Drive Silver Spring, Maryland 20910 Janice M. Goldman (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Beltsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 22. Name and Address of FacilityRapp Funeral & Cremation Service 21. Signature of Funeral Service Licensee M00982 933 Gist Ave. Silver Spring, Maryland 20910 **E** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ornerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA After this funeral of Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after use.....

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 3 🔲 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and a 🕏 person who completed cause of death (Item 23a) (Type, Print) akoma 32. Registrar's Signature 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	For State Registrar	State o	f Marylan	-	artment			and Me		jiene eg. No:-	009	25217
	D1		1. Decedent's Name (First, Middle	, Last)						1	2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic	al	Arline East G								August	5, 20	009	3:55 P M
	Examin		4a. Facility Name (If not institution						Location o				unty of Death	
			715 Maiden Ch	oice Lane	7. Age (In yrs.	lact hirthday)	If Under		ville		8. Date of Birth		imore	place (State or Foreign
	Funeral Director		5. Social Security Number 223-10-2143	1 M 2 M F	94	Yrs.	Months	Days	Hours	Min	Month, Day Feb. 2,	. Year)	Cou	ntry) ginia
		b	Usual Residence of Decedent											
	ylan how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 🔯 No
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	death with the Maryland rms 23a or 28a-f show rmst Lect willight at	eral	715 Maiden Cho		edent Ever in U	S. 13	Was Deced	212 ent of Hi		gin? (Spec	ify Yes or No-		Race - Ameri	
320	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examinating and event, the Medical Examinating or mast be a pulling at	by Funeral	1 Never Married 2 Marr 3 ☑ Widowed 4 Divorced	Armed Fo	orces? 2 XNo ve		If Yes, spec 1 ☐ Yes 2		Specify:	, Puèrto R	oify Yes or No- lican, etc.)		Black, White, ecify: W	etc. hite
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Maryland	2 should be and Mental is markad sumatic ev	ဥ	19a. Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Numbe	er or Rural	Route Numbe	r, City or To	own, State, Zij	p Code)
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Baitimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Juneral Service	Lice of the Market	7/1	F1	2. Name an	d Addres	s of Facilit	ySter Cato	ling As nsville	shton e. Inc	Schwar	) Witzke ) 21228
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O. Box	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	itcome of pregn birth 2 ☐ Feta nant at time of d nown	al death 3	⊒Ectopic pr ⊒ Other (sp					23d	I. Date of delive Month	very Day Year
rds, P	S C 0	by	Part II. Other significant condition	ons contributing to	seath but not res	sulting in the u	ınderlying c	ause give	en in Part I			obacco use ′es 2□N		the cause of death?
Hecord	e taw require has been siç je 2 should b	Completed									24a. Was autop		24b. Were aut prior to co death?	opsy findings available ompletion of cause of
	Th ate pag	S										2 No	1 Yes	2 🗆 No
<u> </u>	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Oth			(Check only o		7011 - 10	
5	Phys this ral di	7.	1 Yes 2 No	1		ER/Outpatie		A	4 🗆 N		ne 5 H sid			ity)
o	ding I h. After funer	tion	1 ☐Natural 5 ☐ Pendir 2 ☐ Accident investi	'9	of Injury oth, Day Year)	Injury	М	8c. Injun Worl 1 □	k? Yes 2 🗍	No				
Division of Vital	To the Hospital or Attending I within 24 hours after death.  To the Funaral Director: Atter completely filled in by the funer	Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	e of Injury - At h ding, etc. <i>(Speci</i>	nome, farm, st	reet, factory	, office		2	8f. Location (S City or Tov	Street and N vn. State)	Number or Rui	ral Route Number,
	na Hospital n 24 hours ne Funaral bletely filled	edical (	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the Examiner: On the and ma	e best of my kn basis of examin nner stated.	owledge, dea ation and/or in	th occurred rvestigation	at the tin , in my o	ne, dat <i>e</i> ar pinion, d <i>e</i> a	nd place, a ath occurre	ed at the time,	date and pla	ace, and due	to the cause(s)
)	To tha within 2 To the complete	Σ	29b. Signature and title of certifie	mp	) 		290	. Licens	e number	147		A Ly	signed (Month	Day, Year)
	5		30. Name and address of person	(15 711	No	an (	Print)	0.	Lan	P	Catu	nsul	t M	) 
	Sta Registi		31. Date filed (Month, Day, Year,	1	Registrar's Sign									
DH	IMH 17 Rev 1/2	001	AUG 0 7 200	9 Clensu	C B.	parse								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year HAYNES SHERRY Ε. 2009 4c. County of Death 4a. Facility Name (If not institution, give street and numbe samare 8. Date of Birth (Month, Day, Year) 9 / 18 / 1957 9. Birthplace (State or Foreign lf Under 5. Social Security Number 7. Age (In yes. If Unde MARYLAND Months Days 1 □ M 2 □ F 219 62 2829 51 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2X No MD BALTIMORE ROSEDALE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 6510 CORKLEY ROAD 21237 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: WHITE 1 ∐Yes 2 🛣 No 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **JAMES** GARRETT GERTRUDE LINTHICUM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6510 CORKLEY ROAD BALTIMORE, MD 21237 DONNA M. DUNCAN / SISTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/8/09 BALTIMORE, MD GARDENS OF FAITH 21. Signatur - Tuneral Service Ucensee 22. Name and Address of Facility  $CVACH/ROSEDALE\ FUNERAL\ HOME$ CHESACO AVE BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ue to ( as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 🕅 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner sician and burial-transit Physician: The law requires that the death certificate be executed nding physician the as atte ō been signed by the should be detached Ö <u>a</u>: of Vital Records, page 2 s certificate Division Hospital or Attending death.

Examiner Physician/Medical ģ Completed After this certification, t Be Medical Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural"

Item 27 Is marked other than "natu other traumatic event, I'm Western

Important: If Its any injury or o once.

**Physician** 

/Medical

Director

Funeral

Completed by

Be

ပ

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.

Baltimore, Mary/and 21215⁄-003

1 Yes 2 No 27. Manner of Death

29a. Certifier

1 Natural 2 Accident 3 Suicide 4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier MD 29c. License number

29d. Date signed (Month, Day, Year)

8.05.2009

Registrar

Day,

9000 Fran anna 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** ବ୍ଧ 2009 Johnny Lee Hunt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** quare Hospital Center Baltimore Kosedale 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1**√2** M 2 □ F Months Hours 09/06/1957 51 213-72-2290 Ohio Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; It a Modical Examination to other traumatic event; It a Modical Examination to other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10b County 10a, State 1 ☐Yes 2X No Director Middle River Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21220 U.S.A. 3230 Miller Avenue, Apt. B Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 □Yes 2X No þ If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maritime Shipping Merchant Marine 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norma Jean Ballenger Lee Beechamb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Greenspring Avenue, Joppa, Maryland 21085 Donna Watts (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory, Inc 08/07/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Lice 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final diseas r condition resulting in death) Brain Tumos **Physician** 2-3 Months /Medical Due to (or as a consequence of): Examiner missonoro artery Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Q. IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was ar autopsy performed? Yes 2 No certificate 1 □ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation ours after death. neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 2 To the I

State Registrar

DHMH 17 Rev 1/2001

Medical

29b. Signature and title of certifier

Tawil

AUG

31. Date filed (Month, Day, )

MD.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Year)

29c. License number

200 68176

9000 Franklin Square Dr Baltimore, Md 21237

29d. Date signed (Month, Day, Year)

08/07/2009

4		
	Physicia	an
	/Medic	
	Examin	er
EX.	2011-02 10000	
	Funeral	
ij.	Director	

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has teen signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-itansit

Division or Vital Records, P.O. Box 68760,

2. Date of Death Year  $A^{M}$ AUGUST 4, 2009 7:27 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 928 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday Hours Months Days **(XXX**M 2 ☐ F Yrs. 2ĺ 544-26-5817 80 Jan. Oregon Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Directo Anne Arundel Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 337 Ellerton S. 20724 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White þ Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Collectors Manager Department of Defense 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harold Leroy Hall Pearl McClellan ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Marie Hall/Wife 337 Ellerton S. Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State West Arundel Crem. 8/6/2009 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 20707 23a. Part1, Enter the disease, or complications, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one lause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of) Aspiration Pneumonia Sequentially list conditions, Due to (or as a conse uence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Cerebrovascular Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe Waldenstroms Macruglorulinemia 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D22966 30. Name and address of person who completed cause of death, Item 23a) (Type, Print) Thomas H. Burguieres, MD 7300 Van Dusen Road, Laurel, MD 32. Registrar's Signatur 31. Date filed (Month, State AUG

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5:35 PM AROU HOOK 4a. Facility Name (If not institution, give street and number) Town or Location of Death 4c. County of Death ALTIMORE WASHINGTON NIEDICAL ENTER 8. Date of Birth (Month, Day, Oct 21, 9. Birthplace (State or Foreign Country) North Carolina 7. Age (In yrs. last birthday) 1 □ M 2 🕅 F Months Days Hours Min. $\overset{\scriptscriptstyle{rear}}{1932}$ 76 238-44-8353 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 □ No Anne Arundel Maryland Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1202 Hillcrest Road 21113 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □XNo Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Payroll Technican 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Haze1 Redict Tommie Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1202 Hillcrest Road

Arlington National Ceme8/31/2009

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

**Physic** /Medi

Department of Health and Maria Hygis Important: If item 27 is marked other any injury or other traumatic event, If sone.

Pages 1 and 2 should be 1 nent of Health and Mental

**Physician** 

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

ပ္

John H. Hook/husband

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice

ianity of

1 XBurial 2 Cremation 3 Removal from State

thomas

20a. Method of Disposition

ed other than "natural", or Items 23a or 28a-f show event, the Medical Exercited resist by recified at

more, Maryland 21215-0036

Exami

or Attending Physician: The law requires that the death certificate be executed Vivision of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death)	a. Serric Sy Due to (or as a conse						Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a conse					5	2440
resulting in death) Last	Due to (or as a conse	quence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al déath 3□Ec	topic pregnancy her (specify)			23d. Date of deliver Month	ry Day Year
9 ☐ Unknown						1	
9 Unknown  Part II. Other significant conditions  CHROPIC OBSTRU				in Part I.		co use contribute to the	
Part II. Other significant conditions				in Part I.		2 No 3 Proba  24b. Were autopprior to comdeath?	ably 4 Unkno
Part II. Other significant conditions  CHROWIC OBSTRU  25. Was case referred to medical	CLIVE BULHON	agzid yua	<b>\$ E</b>		1 🔀 Yes  24a. Was an autopsy performed'	2 No 3 Proba  24b. Were autopprior to comdeath?	ably 4 Unkno
Part II. Other significant conditions  CHRONIC OBSTRU	CLIVE BULHON	agzid yua	<b>\$ E</b>	6. Place of De	1 <b>K</b> Yes  24a. Was an autopsy performed' 1 □ Yes 2 <b>K</b> ath (Check only one)	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes 2	ably 4 ☐ Unknossy findings available tion of cause 2 🔀 No
Part II. Other significant conditions  CHROPIC OBSTRUE  25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of Injury	2B DCA Other: 28c. Injury a Work?	6. Place of De 4 □ Nursing I	1 🔀 Yes  24a. Was an autopsy performed' 1 □ Yes 2 🔀	2 No 3 Proba  24b. Were autopprior to comdeath? No 1 Yes 2	ably 4 ☐ Unknossy findings available tion of cause 2 🔀 No

1411 Annapolis Road Odenton, Maryland 21113 Approximate Interval Between Onset and Death 24404 2440 2 23d. Date of delivery Month Day Year

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Odenton, Maryland 21113

20c. Location - City or Town, State

Arlington, Virginia

Date

22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ation, in my opinion, death occurred at the time	
29c. License number	29d Date signed (Month, Day, Year)

41753000

AUGUST 2, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUILLERMO JOSÉ	GIANGRECO 30	JATI920H	DRIVE, GLEN	BURNIE.	MD 2016
31. Date filed (Month, Day, Year)	32 Registrar's Signature				

State Registrar

Me conference son surrelled

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year William Aygus 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** arc 9 Himore olon 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Year) 1 🖳 M 2 🗆 F Months Days Hours 218--18-2091 Director 1924 | Maryland 85 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heathh and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be rediffed at 1 DaYes 2 □ No Director N/A Baltimore Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 301 McMechan Street Apt. 202 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1XXYes 2 □ No If Yes, Give Year or Dates: WW2 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☐ No Specify: <u>۾</u> 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Laborer 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Mae Worthington Henry Mayor Hill ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3604 Bowers Ave Apt.B Baltimore, Md 21207 Alfreda Hall/ God Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemeter Baltimore,Md 21. Signature of Funeral Survice Livensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Varis 28a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final **Physician** disease or condition resulting in death) arcinoms /Medical Tue to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): burialattending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate Division of Vital 1 □Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 NO ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending death. investigation after death Director; / d in by the f 1 ☐ Yes 2 ☐ No 3 Suicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely (Check only one) within 2

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jacem

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

503

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 2:15 PΜ August GENE VINCENT HAINES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country)

PA 8. Date of Birth (Month, Pay, Year)
Dec 12, 1954 Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 □ F Months Dec. 54 **Director** 217–58–8642 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar management. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Directo Walkersville MD Frederick 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code USA 21793 Funeral 20 Williams St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1√ Yes 2 No 14. Race - American Indian. 11. Marital Status TYPYes 2 No If Yes, Give Year or Dates: 1974 1 Never Married 2 ☐ Married 1 ☐Yes 2 【XNo Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) manufacturing 12 machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Johnson ဂ John B. Haines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walkersville, MD 21793 20 Williams St. Dorothy Long/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 Removal from State 4 Donation 5,☐Other (Specify) 8/8/2009 Sykesville, MD County Cremation 21. Signature of Funeral Service 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ANOX,6 0455 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Acute Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-trar attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death Funeral Director;

Natural 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

MO5/616

29d. Date signed (Month, Day, Year) 09

2170

State Registrar

completely

within 2

Medical

29b. Signature and title of certifier

ane 32. Registrar's Signature Year) 31. Date filed (Month, Day, AUG 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 25224 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Dav Physician Month Vear Joseph N. Henryhand 07/30/2009 18:40 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 2002 Wilkens Avenue If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours SC **1**√2 M 2 □ F 250-58-0213 71 Director 10 28 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show ital Hygiene. d other than "natural", or items 23a or 28a-f sh event, the Midcal Evan, inc. ust by ricitified. 1 XYes 2 No Director Baltimore M D 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 2002 Wilkens Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ NO If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, traingnes. Freight Con Railworker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cassie McBride William Henryhand ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Wilkens Avenue, Baltimore, Maryland 21223 Helen McNeil/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 08/08/2009 Woodlawn, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Homes of Baltimore County 9200 Liberty Road, Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 mu /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of) Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached t o 9 Unknown 9 signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 2 **N**0 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed? 1 □ Yes 2 No of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending investigation within 24 hours after dea h.

To the Funeral Director A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check anly one) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) TEMINUL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (ROSSROAN) 31. Date filed (Month, Day, 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Harrison Renee /Medical

Reg. No. Date of Death
 Month 02 2009 AUGUST 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NA SINAI HOSPITAL OF BALTIMORE CIT BALTIMORE Birthplace (State or Foreign Country)
 MD Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 04-12-5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2√□F 220-78-9219 44 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at XXYes 2 No Director MD NA Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21223 530 N. Payson Street Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 □ Yes 2 ☑ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: American Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th Grade Greg's Place Bartender 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miller Gloria should be Conquest Enoch Wayde ၉ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4031 Twin Circle Way Baltimore, MD 21227 Department of Health a Important: If Item 27 is any injury or other tra Paul Edward Harrison of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 08-10-09 Owings Mills, Md Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 lie 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRA CRANIAL (VENTRIWLAR & CEREBRAL) HEMORPHAGE 1 day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 🛂 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₩No 1 A Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral I funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 02, 2009 MBBS RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJEEV GUPTA, MBBS, SINAL HOSPILAL OF

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

HARAISON, RENEE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Waltraut 12:15 P™ Hagen 6, 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 11112 Harford Road Glen Arm If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/08/1926 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 □ M 2√2 F 218-26-9922 83 MD Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show MD Baltimore Glen Arm 1 ☐ Yes 2 ☐ No 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21057 USA 11112 Harford Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Specify. White þ Specify: 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Manufacture 12 Secretary h and Mental Hygien 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Petranek Buchholz Elise Otto 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra |11112 Harford Road, Glen Arm, MD 21057 Barbara McCrea / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Ardent Crematory 8/7/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall Dawto Marsha <u>212</u>03 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mo, e of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** physema 1040015 /Medical Due to (ar a a consequence of): Examiner Thing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fir as a consequence Examiner the death certificate be executed burial-trar and Due to (or as a consequence of): physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 TvNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. I or Attend after death. Director: / 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital \*\*Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

altimore, Maryland 21215-0036

Box 68760,

Records, P.O.

Division or Vital

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Wiegwann

31. Date filed (Month, Day, /Year)

AUG 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Robert Russell Hines August 2:40 PM 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Doctor's Community Hospital Prince George's Lanham Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 8/6/1957 If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 XM 2 □ F 51 220-70-1750 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Timonium MD Baltimore 1 ∏Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 3 Dalec: 21093 USA Dalecrest Court, Apt. 304 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ∐Yes 2 🛣 No Specify: Specify: 3 ☐ Widowed 4 X Xivorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Automotive Automotive Inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jene Jameson Jim Hines ationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Hines / Daughter 3 Dalecrest Ct, Apt. 304, Timonium, MD 21093 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Ardent crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 8/6/2009 Hanover, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21. Signature of Funeral Service License Dorota Marshall W. Marshall ouche Baltimore, MD 21203 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ARHYTHMIA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 2 ☐ No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

/Medical Examiner be executed Box 68760, P.O. Division of Vital Records,

sician and burial-trans attending physician for use as the buria Physician/Medical detached signed by 1 I be detach icate has been si , page 2 should b Completed Hospital or Attending Physician: The 124 hours after death.
Funeral Director: After this certificate h. Be Certification: To funeral filled in by the within 24 hours a To the Funeral C Medical completely

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Funeral

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Completed

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?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Maches Examiner must be notified at

72 hours after

s 1 and 2 should be filed wi f Health and Mental Hygien item 27 is marked other th

permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr

Physician

Maryland 21215-0036

Baltimore,

29a, Certifier

2 Accident 3 Suicide 4 Homicide

1 Yes 2 No 27. Manner of Death 1 Natural

5 ☐ Pending investigation

6 ☐ Could not be

28b. Time of 28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 1 □Yes 2 □No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier Shoth

M0054675

29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shobhit Arora 8118 Good hack Rd, Laskam, mo. 20106 mi

31. Date filed (Month, Day, Year) State AUG 07 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3:527 M Lillian Gertrude Hollar 2000 August 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hospital 1ane Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Days Min Hours 1 □ M 2 🖾 F Maryland 220-10-7453 89 5, 1920 Aug. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 🕅 No Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 640 North Bend Road 21229 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Asbury Rice Bird Anna May Porterfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 640 North Bend Road; Baltimore, MD 21229 Richard M. Hollar Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Garden 8/10/2009 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee MO1050 23a. Part1. Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Ylen Due to (or as a consequence of) Wee Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 242No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes Other (Specify) curred

Examiner burial-trar Division of Vital Records, P.O. Box 68760, attending physician the nse õ the detached signed by To the Hospital or Attending Physician: The law require within 24 hours aller dealh.

To the Funeral Lirector After this certificate has been sit completely filled in by the funeral director, page 2 should I

Physician

/Medical

Examiner

Director

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Completed

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Physician/Medical

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Certification: To

Medical

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinat must be notified at

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

12

State Registrar

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25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manne of Death 1	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  28c. Injury at Work?  1 □ Yes 2 □ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	of. Location (Street and Number or Rural Route Number, City or Town, State)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License numb

29d. Date signed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

teractac

31. Date filed (Month, Day, Year)
AUG 0 7 20

29b. Signature and title of certifier

29a. Certifier

32. Registrar's Signature

			Please Type or Print in I						
		_	State of Marylar  1 - State Registrar	•	artment of F rtificate of I			iene :g. No:?	25220
			Decedent's Name (First, Middle, Last)				2. Date of Deat	h	3. Time of Death
	Physicia /Medic		Robert O. Insl	ceep	·		08-02-2	Day Year	1130 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Dea	
pol <sup>et</sup>		£ 1-	309 Tiree Ct #202  5. Social Security Number   6. Sex.   7. Age (In yrs	last hirthday	Abingd If Under 1 Year	On. If Under 24 Hrs.	8. Date of Birth	Harfor	rthplace (State or Foreign
	Funeral Director		217-14-4812 DAM 20F 87	Yrs.	Months Days	Hours Min.	(Month, Day, 04-08-19	Year) C	MD
	ъ		Usual Residence of Decedent	ity, Town or Lo	cotion				10d. Inside City Limits
	larylar	ō	10a. State 10b. County Harfold R	OI A	ic MD				1 □Yes 2 □No
	the N	rect	10e. Street and Number	1017	10f. Zip Code		1	0g. Citizen of What C	Country?
	th with	Funeral Director	309-5 Tiree Ct Apt 2	02	4	21009		USA	
	tems	nuel	11. Marital Status  12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	
36	rs afte	by F	1  Never Married 2  Married 1		1 □Yes 2 No	Specify:		Specify: W	hite
21215-0036	flied within 72 hours after death with the Maryland Hygiene. Hygiene. sther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup	pation during most of work	ina I	16b. Kind of Busines	s/Industry
2	rithin 7 ne. han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired et Analys	during most of work d) +		Federal G	lov¹ t
2	filed w Hygie ther ti	S	12 17. Father's Name (First, Middle, Last)	Duug	et Allarys	18. Mother's Name	e (First, Middle, f		10 V C
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print)					City or Town, State	
Š	and 2 lealth m 27 i		Gary R. Inskeep (Son)		0 Queensb	7		MD 21047	
Baltimore,	ages 1 nt of F if ite				osition (Name of ematory or other place				
<u>=</u>	nit. Pa artme ortant injury	- 4	4 □ Donation 5 □ Other (Specify) H1  21. Signature of Funeral Service Licensee					Fallston, Euperal Ho	me of BelAir
Ba	permi Depar Impor any ir	2	Diano Franco					L Air, MD	
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Sign Park	Physician		Immediate Cause (Final disease or condition	andia	il Info	arction			Ove hour
	/Medical Examiner		resulting in death)  Due to (or as a conse	and the second	Arter	1 Dilea	10		Five years
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H	e execbted ian and ırial-transi	Examiner	Cause (Disease or injury that initiated events c.						
₹) 20,°	Attending Physician: The law requires that the death certificate be executed redeath.  cross. After this certificate has been signed by the attending physician and betor. After this certificate should be detached for use as the burial-transity the fumeral director, page 2 should be detached for use as the burial-transity.	_	resulting in death) Last Due to (or as a conse	quence of):					
Box 6876	leath certificate be attending physici I for use as the bu	Physician/Medica	d						
ŏ	n certii ending use as	n/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fe		☐ Ectopic pregnan	01/		23d. Date of	
B	ed for	sicia	1 Yes 2 No 4 Pregnant at time of		Other (specify)			Month	Day Year
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my ki (Check only one) 2 Medical Examiner: On the basis of exami and manner stated.	nowledge, dea nation and/or	ath occurred at the t investigation, in my	time, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and c	r as stated. due to the cause(s)
	To the within 2 To the Comple	Mec	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
	F > F 0		Kem Snuder mD		D	33642	_	August	04,2009
			30. Name and address of person who completed cause of death (It	em 23a) (Type	Print)	Are	ROLLA	r MI)	21014
	Sta	te	31. Date filed (Month, Day, Year)  32 Registrar's Sig	nature		FLOC		VVI	
	Registi		AUG 07 2009 De Deve	B. A.	St. Sal				

amend #31 Per DVR G894 8/07/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 07-29-2009 Stanley Vincent Johnson Sr. 6:23 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 □ F Months Days 213-28-6046 78 Director June 28,1931 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State d other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be notified at 1 ☐ Yes 2√XNo Director Baltimore Edgemere 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2516 Sycamore Avenue 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver A.B.F. 10th Grade permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 is marked other i any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Morton Minnie Johnson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine M. Johnson/ Wife 2516 Sycamore Ave. Edgemere, MD 21219 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Nother (Specify) Entombment Holly Hill Mem Gardens
Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD toarre Chatman-Harris F.H 4210 Belair Rd 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) thens dentic 1)wna 1sease **Physician** /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physlcian; The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 🗆 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was case record to merical examiner? within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 2 MNo 1 ☐ Yes 1 Yes Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lephens 200 Noilh 32. Registrar's Signature 31. Date filed (Mogth, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Cleveland Jenkins Saunders 2009 11:45 pm 4 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 915 Cator Avenue Baltimore, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min Days Hours 1 🕱 M 2 🗆 F 230-22-8136 85 01/01/1924 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Baltimore 1 DXYes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21218 USA 915 Cator Avenue filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc 1gYes 2□No IfYes, Give US Army Year or Dates.US Army 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 📆 No Specify. ğ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Manufacture Welder Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be in and 2 should be file. Health and Mental Heman 27 is marked offer the standard offer and the standard offer and the standard offer and standard Banks Wesley Jenkins Annie Mazzie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any in]ury or other trau 915 Cator Ave, Baltimore, MD 21218 Herman Jenkins / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Ardent Crematory 8/5/2009 Hanover, 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License Dorota Marshal 12. Name and Address of Eacility
Maryland Cremation Services
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Progressive **Physician** disease or condition resulting in death) Due to (or a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) P.O. the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv performed' certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 🗆 Nursing Home 5 🗷 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Paffer death. After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

24 hours a Hospital within 2

> State Registrar

Medical

29a. Certifier

(Check only one)

29b, Signature and title of gertifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

MD

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State of Maryland / Department of Health and Mental Hygiene 2 U

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death .Dav 2009 **Physician** 3 /Medical 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number Examiner BALTIMORE BALTIMORE DICE NORTHWEST If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day) **Funeral** Months Min Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1XYes 2 □ No Director ALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be or other traumatic ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) Department of Health a Important: If item 27 is any injury or other trauonce. SULLIVAN Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State LANSTOWNE. 4 Donation 5 Dother (Specify) permit. 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EREBROVASCU **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy signed by the atte in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify 170 SPCE Hospital: 1 ☐ Yes 2V/No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

2835 SMITH NE SUTE ZOS Baltimore MD NOOP 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day Month **Physician** Kaur August 22:53 M 2009 Dawaran /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore City Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Country Months 1 □ M 2 🗓 F 08-27-1929 216-17-0577 79 India Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~... any injury or other traumatic exercise. 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 ☐ Yes 2X No **Funeral Director** MD Boyds Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code India 20841 18109 Dark Star Way 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 2 X No 1 □ Never Married 2 □ Married 1 □Yes 2X No Asian <u>Indian</u> Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dault Singh Mohinder Kaur ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Narander Kaur / Daughter 18109 Dark Star Way Boyds, Maryland 20841 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Arundel Crematory | 08-06-2009 | Odenton, Maryland 4 □ Donation 5 □ Other (Specify) W. 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A 1411 Annapolis Road Odenton, Maryland 21113 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Inju. y that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical aftending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 ☐ Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N Wolfe Street Baltimore, Maryland 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

09-05489 Carl Lynch Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physician	Registrar	2.	Reg. No. Date of Death 3. Time of Death	ath
ledical Examine			Month Day Year 2350 hrs	3
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
	Suburban Hospital	Bethesda	Montgomery  i. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Birth)	
Funeral Director	5. Social Security Number unk 6. Sex  1 M 2 F  7. Age (In yrs. last bit		pril 10, 1957 Country)	-
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location	10d. Inside C	ity Limits
≱	DC Washington, DC Washir	gton, DC	1 Yes 2	2 X No
Aaryland 28a-f show 1 at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?	
the N Sa or 2		20020	USA	
h with	11. Marital Status unk 1 Never Married 2 Married 12. Was Decedent Ever, in U.S. Armed Forces? Unk 1 Yes 2 No	13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- 14. Race - American Indian, Bla van, etc.) White, etc.	ack,
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2127 2127 Wild be a Mental marke is event	0 19a. Informant's Name/Relationship (Type, Print ) 19	9b Mailing Address (Street and Number or Rur	al Route Number, City or Town, State, Zip Code)	
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Fe, N I and Health Fitem		of Disposition (Name of cemetery, atory or other place)	ate 20c. Location - City or Town, State	
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Baltimore, Demir. Pages I an Department of Hea Important: If ite	21. Signalure of Funer   Service Licensee Renald S. Wall, prector	22 Name and Address of Facility Board	655 W. Baltimore Stree	t
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Physician /Medical	failure. List only one cause on each line.	lot enter the mode of dying, such as caldiac of the	Between O	nset and
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tal Records, P.O. Box 687 cian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as to	Acquired Immunodifiency Syndromore Hepatitis B		autopsy prior to completion of death?  1 ✓ Yes 2 No 1 ✓ Yes 2	No No
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Division of Vital Records, tal or Attending Physician: The law requir as after death.  al Director: After this certificate has been s led in by the funeral director, page 2 should the funeral director, page 2 should have	27 Manner of Death 28a Date of Injury 28h		d. Describe how injury occurred	
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lospita   hours   uneral	1 29a, Centiler	enth occurred at the time, date and place, and di	ue to the cause(s) and manner as stated	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be deached for use as the completely filled in by the funeral director, page 2.	(Check only 1 Certifying Physician: To the best or my knowledge, done) 2 Medical Examiner: On the basis of examination and/or and marine stated.  29b. Signature and title of certifier	r investigation, in my opinion, death occurred at t	the time, date and place, and due to the cause(s)	
To COL	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year	-)
	1/ mi	O.C.M.E.	July 14, 2009	
	30. Name and address of person who completed cause of death (Item 23a			
		Penn Street, Baltimore, MD 21201		
Sta Registra	te 31. Date filed (Month, Day, Year)  32. Registrar's Signature ar  32. Registrar's Signature	harles		

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	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		217-22-1709	X M 2□ F 81	Yrs.			02/10/	1928	Ohio	<u> </u>
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	the h	Director	MD Baltim  10e. Street and Number	ore Ba	altimo	re 10f. Zip Code			10g. Citizen of	f What Coun	try?
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Z	shoul nd M mari mari	F	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street	and Number or Rur			n, State, Zip	Code)
M	and 2 sealth a n 27 is her trau		Denise A. Rutko	wski (daughter)	7407	Brookwoo	od Avenue	- Balt	imore,	Mryla	nd 21236
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Ë	Page nent o nt: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				Cem. 08/1	0/2009	Baltin	nore, l	Maryland
3altimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		21. Signature of Funeral Service Lice			2. Name and Addre					Home, P.A.
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			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. one cause on each line.	. Do not en	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,	1	Approximate Interval Between Onset and Death
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and the	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
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O. E	e dea the at red fo	Completed by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	eath 5[	Other (specify) _				inontin	Day Tour
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9			30. Name and address of person who	completed cause of death (Item	23a) (Tuno	Print)	11/12		0 [	wico	~
			JACKIE JONES, CR				TIMONIUM	MD 21	093		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signat		MO •		Land Land			
	Regist	rar	AUG @ 7 2009	Denver for	CONTO.	D					
				Coy p	1						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** William Giltz Laynor, Jr. Aug 1, 2009 11:39 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Ellicott City 3701 Chateau Ridge Dr. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 Ø M 2 □ F Director MD 215-30-3106 Jan 16, 1934 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event or must be neithfied at 10b. County 1 ☐Yes 2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3701 Chateau Ridge Dr. 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 10/7/1955 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: \$ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Engineering 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Giltz Laynor Sr. ဂ္ Mary Ellizabeth Parr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shirley Y. Laynor Spouse 3701 Chateau Ridge Dr. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aug 03, 2009 Glen Burnie, MD Atlantic Crematory, LLC 21. Signature of Funer 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Division of Vital Records, P.O. Box 68760,5 Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 5 Other (specify) □Yes 2□No signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown nis certificate has been s director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 □No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO D0061624 unes 30. Name and address of person who completed ca 35 of death (Item 23a) (Type, Print) (2) Oncology 11065 Little Partuxent Parkway Columbia, MD 2104 Manyland 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

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Registr	ar

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		For State OF IVE	aryianu	Certificate			eg. No. 2	9 25237
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and		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
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th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1115 SCOTTS HILL DRIVE		10f. Zip (	21208		0g. Citizen of What	SA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if it is redical Evertines must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Armed Forces?  1 □ Yes 2 ☑  1f Yes, Give Year or Dates:		. 13. Was Decede If Yes, specif	nt of Hispanic Origin? (S y Cuban, Mexican, Puert     No <i>Sp</i> ec <i>ity:</i>	pecify Yes or No- p Rican, etc.)	14. Race - Al Black, WI Specify. WH	merican Indian, nite, etc. ITE
n 72 hou "nature edicel E	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during most of wor retired)		16b. Kind of Busine	ss/Industry
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permit. EDepartm Importar any injur		2). Signature of Funeral Service Licenses	211	22. Name and	Address of Facility 50 EISTERSTOWN	L LEVINS	ON & BROS	., INC.
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To the Hospital or Attene within 24 hours after death To the Funeral Director; completely filled in by the	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the bess and manner s	of examinat	wledge, death occurred tion and/or investigation,	t the time, date and place in my opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
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ļ		Mul H.D.	death //:		RES 000	1_	August 6	
		30. Name and address of person who completed cause of Vu Dang HD Sing Hb.  31. Date filed (Month, Day, Year)  AUG 0 7 2009	spital	of Baltimol	e, 2401 W	Belvede	re Ave, Ba	Itimare MD 21215
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	Physicia /Medic		Cathleen O.Morris	07	07 2009 /2:25 AM
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-8	Funeral		Johns Hopkins Baynew Medical Center Balfimore C  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2  1 M 2 X F 84 Yrs Months Days Hours	24 H/s. 8. Date of Birth	9. Birthplace (State or Foreign
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	pu 🖈		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
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	the N	Director	Md. Harford Bel Air  10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country?
	h with	ai Di	1403 Lytham Ct. 21015		USA
	ems :	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, I'm Marlich E'ra i i'm i'm i'm i'm chilling a	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Xes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☐ Xivo Specify: Year or Dates:		Specify: White
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and	be fill ntal H ed oth	Be	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	er's Name <i>(First, Middle, Mai</i> Live Knight	den Surname)
Maryland 21215-0036	should nd Me mark mark	ပ္	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number	0	ity or Town, State, Zip Code)
Σ S	nd 2 s alth an 27 is r trau			Bel Air. Md.	21015
ore,	Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mendal Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, It as its lost it is not other traumatic event, It as its lost it is its lost in the could be a second or other traumatic event, It as its lost its lost in the could be a second or other traumatic event, It as its lost its lost in the could be a second or other traumatic event, It as its lost in the could be a second or other traumatic event, It as its lost in the could be a second or other traumatic event, It as its lost in the could be a second or other traumatic event.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)		c. Location - City or Town, State
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Baltimore,	permit. Page Department of Important: If any Injury or once.	. ,,	21. Signature of Funeral Service Licensee  22. Name and Address of Facilit  Brîan Willem per dvr  610 W. MacPha	ty Schimunek 1 ail Rd. Bel A:	Funeral Home ir. Md. 21014
			23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as		
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	Yo the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending, completely filled in by the funeral director, page 2 should be detached for use as		Unknown  29a. Certifier 1 7 lifying Physician: To the best of my knowledge, death occurred at the time, date an	and place, and due to the cau	se(s) and manner as stated.
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	Nat and a second	Σ	29b. Signature and title of certifier  29c. License number		. Date signed (Month, Day, Year)
	5		Michel + Bellestons, MD D3331	6	07 08 2009
_	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michele F. Bellantoni MD 5505 Hoolen's Boyung	Cial D	07 08 2009 altimor MO 2/229
	Sta	te	31. Date filed (Month, Day, Year) 3% Registrar's Signature	JUNE B	(17/11/167 1110 6100)
	Registr		Alla 07 2009 Jane B. Sarles		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day **Physician** Emma Jane Martin 1:59P.M 2\_ 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Center Gilchrist 8. Date of Birth (Month, Day, Year)

Dec. 26,1926Virginia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days Hours Min. 1 □ M 2√2 F 223-20-1014 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location
Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examination routified an once. N/A Maryland 1 X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21217 2136 Mount Royal Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private family Cook 7th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Jones John Allen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4235 Nadine Drive Baltimore, Maryland 21215 Dorothy Bethea 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 8/7/09 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature Funeral Service Lice 5240 Reisterstown Rd Baltimore, Md 21215 Approximate Interval Between Onset and Death ハハドハルが 23a. Part / Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest so ick, or heart / silure. List only one cause on each line. diate Cause (Final metastat **Physician** astric carain disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 5 Other (specify) P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. SINING 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed vascular 2 | No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) TOSO IC 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death
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Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ca and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

30 Vame and address of person who completed cause of death (Item 23a) (Type, Print) Elon MV

6 2. Registrar's Signature

secc

3. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.

AMEND TIEM# PerPHYS, G894, 877, 709, WS
State of Maryland / Department of Health and Mental Hygiene () [] [] [] Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) John Randolph Miller, 2 Date of Death 3. Time of Death Month 1:05P M **Physician** August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 - F Yrs 9, 004-44-5548 64 **Director** Feb. 1945 Florida Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2X No Director Maryland Baltimore Timonium 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ö Pages 1 and 2 should be filed within 72 hours after death with Examiner must be items 23a 21093 2411 Hartfell Road Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 'natural", or 1 Yes 2X No Specify: Completed by Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than Director of General Services State of Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Nea1 0<u>ak</u> Miller ၉ Madeline Connelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tran <u>Mary E. Miller</u> Wife <u>2411 Hartfell Road</u> Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 📆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-6-2009 Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home., Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a. Respiratory

Due to (or as a consequence of): tailure disease or condition resulting in death) /Medical Examiner Associate d entilator Seque traffy flet out after any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Neutropenic

Due to (or as a consequence of): The law requires that the death certificate be executed tever y physician and as the burial-trant Division of Vital Records, P.O. Box 68760 Physician/Medical 109 as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 mont Month Day Year Pregnant at time of death
Unknown 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has bage ; 24 No 1 ☐ Yes 2 ☐ No Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Y 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: A 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 - Homicide City or Town, State) or 24 hour,
or the Funeral Dr
completely fille Hospital 29a. Certifier (check only 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar AUG 0 7 2

Natasha

31. Date filed (Month, Day, Year)

Fontain e

32. Registrar's Signature

on

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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KES-OOM

August 5, 2009

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Year **Physician** 0056 Maura 04 charles 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Randalls town Baltimore Northwest If Under 1 Year | If Under 24 Hrs.

Months Davs Hours Min. 8. Date of Birth (Month, Day, Year)
08-29-1930 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1 M 2 □ F 245-50-3733 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 범 1 ☐ Yes 2 ☐ No d 2 should be filed within 72 hours after death with the Mary th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f sh traumatic event, it marical Fant, must be milled. Halls. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑ No Specify 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tastal river 2 years 12 years 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 & Department of Health ar Important: If item 27 Is any Injury or other trau alistoun, MDZ1133 eborah J. Mau 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8708 andallstorm 23a. Part 1. Enter the Misease, or complications that caused the death. Do not enter the mode of dying, such as cardiaclar respiratory arrest, shock, or heart fail not List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Acchythmia **Physician** /Medical Due to (or as a consequence of): Examiner coronary ar ter Sequentially list conditions, if any least to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hypotension Due to (or as a consequence of) attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Diabetes Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No signed by the a 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📜 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐Yes 2 XNo 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1∐Yes 2XNo Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the telety filled in by the funera 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D006873 08/04/ 2009 MD Northwest Hospital ER-7 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) L. deWit MD

DHMH 17 Rev 1/2001

State Registrar Michael

32. Registrar's Signature

31. Date filed (Month, Day,

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 2009 Kathleen Ann Meyer 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BURNIE BALTIMORE WASHINGTON MEDICAL CENTRIC Civen

If Under 1 Year | If Under 24 Hrs.

1/297 P3 4 5ar)

Days

21061

10f. Zip Code

Birthplace (State or Foreign Country) MD

10g. Citizen of What Country?

USA

Month

Glen Burnie MD

Day

Were autopsy findings available prior to completion of cause of death?

2 No

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2X No

**Physician** /Medical Examiner

214-46-1129

10e Street and Number

10a. State

MD

Usual Residence of Decedent

8012 Phirne Road E.

**Funeral** Director show

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinations to collect traumatic event, the Medical Examinations to collect the medical Examinations.

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**Physician** /Medical Examiner

sician and burial-trans attending physician for use as the buria signed by the a The law requires that the been si has To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

P.O. Box 68760,

Division of Vital Records,

Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 X No 1 ☐ Never Married 2X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: white <u>8</u> 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Component Prep 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Albert F. Kahler Sr. Virginia K. Addis ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8012 Phirne Rd E, Glen Burnie MD 21061 Mr Charles J. Meyer/spouse Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/11/2009 Catonsville MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 21. Signature of Funeral Service License M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Enler the sealer or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STACE (HEARIC OBGREGIVE KU Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) □Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **□** No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manny of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur and title of certifier

7. Age (In yrs. last birthday)

10c. City, Town or Location

Glen Burnie

64

1 □ M 2 🕅 F

Anne Arundel

State

Registrar

30. Name and address of person whi

31. Date filed (Month, Day Year)

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

4/84

301

072009

Division or Vital Records, P.O. Box 68760 within 24

> State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Mem 23a) (Type, Print)

W. A. K. (2) G.B.M.C. 6701 A

32. Registrar's Signature

N. Charles St. Balto. Md 2120x

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### David Nordaces Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physici	an/	1. Decedent's Name (First, Middl							2. Date of Month	Da	ay Year	3. Time of Death — 2242 hrs	
edical Exam	iner	Jeffrey David  4a. Facility Name (if not institution		umber)		b. City, T	own, or Lo	cation of D	July 23 Death	3, 2009	4c. County of Deatl		
		Interstate 70 Eastbou				Hager	stown				Washington		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde	r 1 Year Davs	If Under 2	4Hrs. 8. Date of	of Birth (N	MM/DD/YYYY) 9. Bir Co	thplace (State or Foreign ountry)	
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any		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Locati	on		_				10d. Inside City Limits	
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2121 wuld be fil Mental I marked c event,	o Be	Arnstein Nordaas  19a. Informant's Name/Relations			19h Mailin	Address	(Street		cy L. Adam		er, City or Town, Stat	e. Zin Code)	
ID 2 shoul and N and N 27 is n	ř	Arnstein Nordaas	(Father)				,				land 21045	,,	
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho rigury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service		1	22.1	Name and	Address	of Facility	Witzke Fu	nera.	1 Homes, Inc		
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Physician /Medical		23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Inte											
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Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	N N	IF FEMALE: 23b. Was decedent pregnant in t		, outcome of problems		etal death	3	Ectopic	oregnancy		23d. Date of delive Month	Pry Day Year	
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Box re death c the atten	Phys		known g Unk					. i. D.	1 220	Did tob	acco uso contributo t	to the cause of death?	
P.O. s that the greed by e detach	by P	Part II. Other significant condi	tions contributing	to death but no	ot resulting in the	unaeriying	cause gr	ven in Pan				obably 4 Unknown	
ords, P.O. B  ν requires that the d s been signed by the should be detached	ted				-					Was an		autopsy findings availabl	
Records, The law requir	1 ≒	\ <del></del>							-   -	autopsy perform	ed? death?		
Vital Rechysician: The this certificate I director, page	. 5	05.10					26 Place	of Death ((		Yes 2	No 1 🗸	Yes 2 No	
/ital	8	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Hor											
of Vital ing Physician After this cert uneral directo	٦	1 Yes 2 No 27. Manner of Death	28a. Da	e of Injury	28b. Time of	Injury	28c. Injury	Injury at Work? 28d. Describe how injury occurred					
ion tendin eath. or: A	] ig	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be 28a. Date of Injury POWND: 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury at Work? 1 X Yes 2 No 28d. Describe how injury occurred victim of helicopter crash 2231 hrs 28b. Time of Injury at Work? 28b. Time of Injury 28b. Time of Injury at Work? 1 X Yes 2 No 28d. Describe how injury occurred victim of helicopter crash 28d. Describe how injury occurre											
Division tal or Attendins after death.  al Director:	ertification:												
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	ical		Physician: To the basi	est of my knowl s of examination	ledge, death occu n and/or investiga	irred at the ation, in m	e time, dat y opinion,	e and place death occ	ce, and due to the urred at the time	e cause( , date ar	(s) and manner as st nd place, and due to	ated. the cause(s)	
To t To t	Medical	29b. Signature and title of certif	and manne	stated.			c. License				29d. Date signed (A		
		0-~	) ~				O.C.N	Л.E.			July 24, 2009		
		30. Name and address of perso	n who completed ca	use of death (It	tem 23a)					1			
61		Donna M. Vincenti, M	·	Medical Ex		1 Penn	Street,	Baltimo	re, MD 2120	1			
نصحت	State	31. Date filed (Month, Day, Year	2009	Registrar's Sign	name Man	Kal							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-i per me, 8894,08/07/09dhb

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Physician 5:17 A M J414 Edward Osborne 2009 John /Medical 4c. County of Death 4b. City, Jown, or Location of Death 4a. Facility Name (If not institution, Examiner T 8. Date of Birth (Month, Day, Ye Jan. 21, If Under 1 Year | If Under 24 Hrs 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 1929 Maryland **Funeral** Hours Months Days 1**⊡**M 2□F 80 218-22-5272 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County пs 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Harford Maryland Belcamp 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21017 1208 Mistwood Court #203 , or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1947– 1 M Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Specify: White 1 ∐ Yes 2 🛣 No Specify: Baltimore, Maryland 21215-0036 ò 3 Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other framman. Elementary/Secondary (0-12) 12 College (1-4or 5+) Law Enforcement Police Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth A. Baumgartner John Wesley Osborne ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8810 Lakewood Road Parkville, Maryland 21234 Steven Osborne / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition July 8, Evans Funeral Chapel 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2009 Forest Hill, Maryland Bel Air 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and A APPROVED BY MEDIC Box 68760, Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 → 1 ☐ Yes 2 ☐ March 2 ☐ 24a. Was an certificate has autopsy pertorm 2 Q No 1∐ Yes 2 E No **Division or Vital** Physician: 25. Was case referred to medical examiner?
1 A Yes 2 Ho 26. Place of Death (Check only one) funeral director, Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury After t Subject slipped and fell in or Attending June 02, 2009 Unknown 5 ☐ Pending investigation Hatural 1 ☐ Yes 2 No  $\mathbf{p}^{\mathsf{M}}$ 2X Accident bathroom within 24 hours after death To the Funeral Director: the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 310 S. Philadelphia Boulevard, Aberdeen, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide completely filled in by 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple 82. Registrar's Signature Date filed (Month, State Parks Registrar

AMEND TTEM# 16a, b. 20a-c. 22perFH, g894,8/12/09 WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8:09 AMM Amelia H. Oconis 2009 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1012 Boyd Street Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Days | Hours | Min. | Dec 29, 1 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 27 F 57 Director 212-60-8883 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County the Medical Examiner must be notified at 1√2 Yes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1012 Boyd Street 21223 USA or items 23a Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritat Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 2 should be filed within 72 l nend Mental Hygiene. 'Is marked other then "nat Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home aregi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gilbert Patrick Lawlor Elizabeth Huppman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Heelth e Elizabeth Feehley/sister 4119 White AVenue Baltimore, MD 21206 permit. Pages 1 and Department of Heelth important: if Item 27 eny injury or other troons. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 8-12-09 Beltsville, MD 4 □Donation 5 □Other (Specify) in state 22. Name and Address of Facility Cafa/Stephen D.Lohrman PA. State Anatomy Board 655 W. Baltimore Str 21. Signature of Funeral Service Licensee
Ronald S. Wade, Darector 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 212018717 Green Pastures Dr. Balto. M. cardiac or respiratory arrest,

Approximate 1286 Interval Between Onset and Death Immediate Cause (Final Hypertension / caronary arreny disease unknow Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner unknown chrone obstructve Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Hypothy nadism ununoun Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. 3 wedge Physician/Medical Preumonia IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) been signed by the is should be detached it ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 1 Yes 2 No 1 Yes 2 XNo To the Hospitei or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 3□ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Sharon Jennem, M.D. august 5, 2009 000648 58 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29 down Paca street. Bathmore, Mayland 21201 Sharon Feinstein 31. Date filed (Month, Day, Year) 32. Registrar's Signature State barkal Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year Day **Physician** 8:08P M NORMA AMELIA PARTRIDGE August 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner STELLA MARIS HOSPICE Timonium
nder 1 Year | If Under 24 Hrs. Baltimore County 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** 6. Sex Hours 1 □ M 2 🕅 F Months Days Min Director 216-12-9302 86 Nov 14,1922 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Timonium Maryland | Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 Hollow Brook Road 21093 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by White Specify: 3 X Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Residence Department of Health and Mental His Important: If item Z7 is marked other any injury or other traumatic eventure. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David James Robinson Alma Armstrong ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Tegtmeyer (Nephew) 114 Hollow Brook Road, Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 8/10/2009 Rosedale, Maryland 21. Signatu ( July I Service Louise Louise 22. Name and Address of Facility MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 mon Month 5 Other (specify) detached 9 T Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 X No Division of Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this HOSPICE funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending al or Attendi s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practition restance). (Check one X Nurse Practit 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2009

9

AUGSUT

NORMA PARTRIDGE

JACKIE JONES,

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

30. Name and agaress of person who completed cause of death (Item 23a) (Type, Print)

CRNP

		1 - State of Mary	•	nent of Health and I cate of Death	Mental Hygien	4767 6007
Physici	an	1. Decedent's Name (First, Middle, Last)  Milton Otto Price Sr.			2. Date of Death	Day January 3. Time of Death
/Medic Examir	er	4a. Facility Name (If not institution, give street and number)  VA MARYLAND HEALTH CARE —	SYSTEM	City, Town, or Location of Death	17 4	c. County of Death
Funeral Director		<b>4</b> ₩ 2□ =	yrs. last birthday) If U Mon Yrs.	nder 1 Year   If Under 24 Hrs. hths Days Hours Min.	8. Date of Birth (Month, Day, Yea 10-03-1919	9. Birthplace (State or Foreign Country)  MD
and		Usual Residence of Decedent	c. City, Town or Location		J	10d. Inside City Limits
If I I I V I II	ctor	MD Harford	Belcamp			1 ☐ Yes 2 🌠 No
with the	Director	10e. Street and Number 4780 #B Water Park Drive	10f	7. Zip Code 21017	10g. C	Citizen of What Country?
er death v	Funeral	11. Marital Status  12. Was Decedent Ever Armed Forces?	in U.S. 13. Was D	ecedent of Hispanic Origin? (S specify Cuban, Mexican, Puert		14. Race - American Indian,
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exempla must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes 2 ☐ No If Yes, Give Ye ar or Dates:		es 2 🕅 No Specify:	Trican, etc.)	Black, White, etc.  Specify: White
215-( in 72 h in matu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind o	Usual Occupation  of work done during most of work  or use retired)	16b.	Kind of Business/Industry
1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	Com	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Senior S	tatistician	ВС	
Maryland 212: Maryland 212: to 2 should be filed within th and Mental Hygiene. 27 Is marked other than traumatic event, the Mental	To Be	17. Father's Name (First, Middle, Last)  Joseph E. Price			e (First, Middle, Maide e Rabenau	en Surname)
Aaryla Laryla Should and Mer Is marke		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Add	tress (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
re, N re, N s 1 and f Health tem 27		Milton Price, Jr. (Son)  20a. Method of Disposition	Ob. Place of Disposition	ater Park Driv		MD 21017 Location - City or Town, State
Baltimore, Baltimore, Dermit. Pages 1 an Department of Heal Moortant: If Item 2 my injury or other once.		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemetery, crematory St. John's	Cemetery 08-0	5-2009 Swe	eet Air, MD
Baltimore, Ma Baltimore, Ma permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any injury or other trau once.		21. Signature of Funeral Service Scensee		ne and Address of Facility Sci 610 W. MacPha		neral Home of BelAir Air, MD 21014
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	TAGE CHRON	mode of dying, such as cardiac		Approximate Interval Between Onset and Death UN KNOWN
Examiner		Due to (or as a consequentially list conditions,	nsequence of):			
uted I Instit	Examiner	if any, leading to immediate Due to (or as a cor cause. Enter Underlying Cause (Disease or Iniury	nsequence of):			
8760, cate be executed by sician and the burial-transit		that initiated events resulting in death) Last	nsequence of):			
crifficate	Medical	d.				
Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the bunal-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant at time 9 □ Unknown	Fetal death 3 Ector	pic pregnancy or (specify)		23d. Date of delivery Month Day Year
ds, P.( ires that the signed by the	by Ph	Part II. Other significant conditions contributing to death but no	t resulting in the underlyi	ng cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
Cord  **require**: been si	eted				1 ☐ Yes	
	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
of Vita Physician: r this certific	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Inpatient	2 ☐ ER/Outpatient 3 ☐	Othor	th (Check only one) ome 5 \sum Residence	6 □Other (Specify)
r g age	Ion: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	25c. Injury at Work?	28d. Describe how inj	
Division  I or Attending after death. Director: After	Certification: To	2 □ Àccident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined 28e. Place of Injury - building, etc. (S)	At home, farm, street, fac pecify)	1 □ Yes 2 □ No ctory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Hospita Hospita 4 hours Funeral	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exa and manner stated, and manner stated.	mination and/or investiga	rred at the time, date and place ation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
To the Within 2 to the comple	Med	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
		Karthaum V.	sorae.	-040713	A	UGUST 1, 2009
		30. Name and address of person who completed cause of death KARITHANOM ISAAC, M.D. VA	(Item 23a) (Type, Print)	EALTH EARESY	STEM, PERA	LOPIL AM THIOS
Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's S	Signature		J	

DHMH 17 Rev 1/2001

NAME KNOWN TO PHYSIELAN: PRICE, MILTON 0 SR.

Baltimore, Maryland 21215-0036

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Samuel Preston, III 09 3:30 AM /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA 1111 Walnut Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth Month, Day, Year) 05-27-68 Birthplace (State or Foreign Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 220-84-8472 41 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I'm Marken Event iner must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with 1111 Walnut Avenue 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Yo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. African Never Married 2☐ Married 1 Yes 2 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: Specify: American Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiens Important: If Item 27 Is marked other the any injury or other traumatic event, IT I SIDES. Engineer Marriott Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel D. Preston, Jr. Michelle Savage ၀ 19a. Informant's Name/Relationship (Type. Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Savage-Chamblee 412 Mt. Holly Street Baltimore, MD 21229 20a. Method of Disposition 14D Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Druidridge Cem. 08-11-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore, 21. Signature of Funeral Service License P.A. MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ta **Physician** 1 car disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 🗽 No 3 ☐ Probably 4 🗍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 No 1 □ Yes 2 🗷 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of

P.0. Division of Vital Records, Hospital or Attending

Preston

Samuel

Baltimore, Maryland 21215-0036

this After this funeral c within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar 1 Natural

3 Suicide

29a, Certifier

2 Accident

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

5 Pending

investigation 6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

া Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

25 mais St Perstert-maz1136

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL NG If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1**X** M 2□ F Months Days Hours Min. NONE Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho HOWARD 1 Xyes 2 No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with t ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or: ury or other traumatic event, the Medical Examiner must be r. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: BLACK If Yes, Give Year or Dates: 1 ☐Yes 2. No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA 14 UF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JEROME PINKNE ပ 19a. Informant's Name/Relationship (Type. Print) FATHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State permit. Page Department of Important; If any Injury or once. 8/8/09 LAUREL, MD MID NATIONAL MOMPK 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERIAL COME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ISCHEMIC ENCEPHALOPATH **Physiclan** 4T BIRTI HYPONC /Medical Due to (or as a consequence of): Examiner SEVERE PEINATAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed LACENTAL attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 ☐No 1 ☐ Yes 2 **N**0 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🔀 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident the 1 after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

Registrar

State

29b. Signature and title of certifier

JANEL

31. Date filed (Month, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HIND

29c. License number

20053569

(Item 23a) (Type, Print)
(HCH) 1500 FOR SEGLEN Ref SILVER SPEING, W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#17, Isperfy, G894, 877709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 8 7:28AM Mie 'age 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mar BaHimor waney Timonium 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Months Days Hours Min 1 □ M 2 🗷 F 22-3720 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at 1 ✓Yes 2 ☐ No MD Director Raltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. 13. W Armed Forces? 1 \( \superset \text{Yes}, \text{ Give year or Dates:} \) USA 21206 by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify 3 Widowed 4 □ Divorced Specify. Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) omestic rivate Department of Health and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Truman Ford Beatrice Robinson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Davien Rd. Ballinove, Mb 21206

Jame of Date 20c. Location - City or Town, State Borbara Orrington/baughter 20a. Method of Disposition 200. Place 5216 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Park Cemetry 0807-07
22. Name and Address of Facility Journal Baltimare, MD 4 □ Donation 5 □ Other (Specify) Greene fundal Sius. 21. Sigrature of Funeral Service Licensee augh . Randallstown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feeture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a conesquence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 2 No 3 Probably 4 Unknown 1 Tes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2**X** No 1 □Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onex Nurse Practitioner as tated. 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009

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spital or Attendi nours after death. neral Director: A r filled in by the fu

To the Hospital o within 24 hours af To the Funeral Di

with the Maryland

Pages 1 and 2 should be filed went of Health and Mental Hygint: If item 27 is marked other

burial-tran

cate has been signed by the attending physician, page 2 should be detached for use as the burial

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

AUGUST

show

State Registrar

JACKIE JONES, CRNP 31. Date filed (Month, Day, Year) AUG 0 7 2009

2300 DULANEY VALLEY RD. 32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 1650 MS 1:05 Рм EON (DS 009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 402 Hurley Avenue Rockville 8. Date of Birth (Month, Day, April 20, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours <sup>Year)</sup> 1916 1 X M 2 □ F Belarus 230-40-4868 93 Yrs. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 290 control of the market of the marke 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director Maryland Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20850 402 Hurley Avenue United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify. White Completed by 3 X Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Secondary (0-12) College (1-4or 5+) Agronomist Virginia 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernhards Pilsums Kristina Mauritis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jokelainen / Daughter 7500 Devries Drive, Lorton, Virginia 22079 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition August 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22, Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee M01305 Robert A. Pumphrey Funeral Home/Rockyill 300 West Montgomery Avenue, Rockvill 23a. Part. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760,~ attending physician for use as the burial ed by the signed t has certificate After this filled in by the

Funeral 24 hours To the

> State Registrar

cal

29a. Certifier

29b. Signature

and title of certifier

Name and address of perso

31. Date filed (Month, Day, Year)

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar			.v.a. y.a	Ce	rtificat	e of L	Death	u u	J	Reg. No.	2009	25	254
	Physici	an	1. Decedent's Nam	e (First, Middle, La	ıst)							2. Date of De	eath Day	Year	3. Time o	_
	/Medi		Rebe		08					02	200	9 1700	PM			
	Examir	ner	4a. Facility Name (1)	Hospico	at the	Lake		Sa	lisb	Location of Ury	. 7		4	County of Dea	1100	
	Funeral Director		5. Social Security N 216-64- Usual Residence of	8447	Sex 7. 1 □ M 2 🔀 F	Age (In yrs. le		If Under Months	Days	Hours	Min.	8. Date of Bi (Month, D 1ay 17	y, Year)	3 Mar	rthplace (State ountry) yland	or Foreign
	/land		10a. State	10b. County		10c. City	, Town or Lo	ocation							10d. Inside (	City Limits
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	th with th	Funeral Director	10e. Street and Nui 5626 Gal	<sup>mber</sup> Lestown N	ewhart M:	ill Roa	ıd	10f. Zip		8873		10g. Citizen of What Country? USA			ountry?	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its It. dical Event instructional be notified at once.	þ	11. Marital Status 1 □ Never Marr 3 ☑ Widowed	ied 2□ Married	12. Was Decede Armed Force 1Yes 2 If Yes, Give Year or Date	es? X∏No	1	Was Deced If Yes, spec 1 □Yes		ispanic Ori in, Mexicar Specify:		cify Yes or Nican, etc.)		4. Race - Am Black, Whi Specify:	erican Indian, te, etc. white	
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Maryland 21215-0036	ould be file Mental Hy arked oth atic event	To Be (	17. Father's Name John Fre		•					Mi	ldred	(First, Middle Lee K	irwan	1		
	and 2 sho ealth and n 27 Is m		19a. Informant's N	ame/Relationship  Miller/			562	6 Ga1	esto.	wn Ne	er or Rural ewhar t	Route Numi	Rd S	Town, State, eaford	Zip Code) , DE 19	973
Baltimore,	Pages 1 and 2 ment of Health ant: If Item 27 Is ury or other tra			position ☐ Cremation 3 ☐ 5 ☐ Other (Speci		20b. Pl	ace of Dispo emetery, crei	osition (Nar matory or o	me of other plac	e)	Da	ite	20c. Loc	ation - City o	r Town, State	
Balt	permit. Pag Department Important: I any injury o		21. Signature of E	onald S.	Wade IX	Lector	St	2. Name ar Late A	Anata	omy B	óard	655 W.	. Balt	imore	Street	
	Physician		23a. Palt1. Enter t sh. k, or hea Immediate Cause disease or condition	on	pplications that cau one cause on eac a. CHRO	sed the death h line.	Do not en	TRU	de of dyin	g, such as	cardiac or	respiratory	arrest,	RASIZ	Approxima Interval Be Onset and	etween
1000	/Medical Examiner	L	resulting in death)  Sequentially list co		b	as a consequ	ence of):									
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ds, P.	w requires that the d been signed by the should be detached	by	Part II. Other signif	ficant conditions	contributing to deat	h but not resu	lting in the u	nderlying c	ause give	en in Part I			tobacco us		to the cause of	death?
Division of Vital Records,	The law req ate has beer page 2 shou	Completed										24a. Was auto perf 1 □ Yes		24b. Were a prior to death? 1 □ Ye		s available cause of
Vita	iclan: certific rector,	Be	25. Was case refer examiner?		Hospital:				TOth	Dr:		(Check only				
ou of	Attending Physician: The Isr death. ector: After this certificate hiby the funeral director, page	ion: To	1 Yes 27. Manner of Leat	th 5 Pending	28a. Date of (Month,	lnjury Day, Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	4 L N	21	e 5 Res		Other (Sp	ecify)	
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 Accident 3 Suicide 4 Homicide	investigatio 6 □ Could not b determined	e 28e. Place of	Injury - At hor , etc. <i>(Specify</i>	me, farm, str			res ZL	-	3f. Location City or To	(Street and wn, State)	Number or F	Rural Route Nu	mber,
	e Hospita 24 hours e Funeral etely filled	Medical C	29a. Certifier (Check only one)	Certifying P	hysician: To the be miner: On the bas and manne	is of examinat	vledge, deat ion and/or in	h occurred evestigation	at the tir n, in my o	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time	e cause(s) , date and	and manner a place, and du	as stated. le to the cause	(s)
	To the within To the comp	Me	29b. Signature and	title of certifier				290	c. License	e number			29d. Date	signed (Mon	nth, Day, Year)	
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ORIGINAL

DHMH 17 Rev 1/2001

Box 68760.

P.O.

of Vital Records.

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month & 48 PM Day Year **Physician** 2009 /Medical Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and gumber) 4b. City. Examiner HECLICA MUMP N/A 9 /And niversit f Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 214-38-6743 67 1942Maryland Director July 29, Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show items 23a or 28a-f shor 1∏Yes 2∏No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5220 York Road Apt.4U 21212 USA Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after □Yes 2 □ No Yes, Give 1 Never Married 27 Married 7 is marked other than "natural", or i traumatic event, the Medical Expression altimore, Maryland 21215-0036 1 ☐ Yes 🔀 🔯 No Specify: Specify: Black ð 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Important: If Item 27 is marked other than any injury or other traumatic event, the Maonce. Elementary/Secondary (0-12) College (1-4or 5+) Printer Print Shop Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frazier Robinson Hattie Spurill ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Robinson/ Wife 902 Marlau Drive Baltimore, Maryland 21212 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/10/09 Greenmount Cemetery Baltimore, Maryland Signature / Funeral Service Licens 22. Name and Address of Facility Chatman-Harris Funeral Home arris 5240 Reisterstown Rd Baltimore, Md 21215 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-tran Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 D Unknown 9 🔲 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ ₩nknown 1 ☐ Yes 2 ☐ No page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 ☑No 2 No director, Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 0 NO 1 Lampatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 💾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Year)

2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 525 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 6:15 PM orence Lore Hu rugust 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death own 9. Birthplace Country) Number Age (In yrs. 8. Date of Birth (Month, Day, Year 1 M 2 K F Months March 17,1946 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 □ No more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 2 Married 1 Never Married 1 ☐ Yes 2 📆 No 3 ☐ Widowed 4 ☒ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) de 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) man 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19a. Informant's Name/Relationship (Type. Print) (SISIEr 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ F 3 Removal from State 2009 re of Funeral Service License 05 ner Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Party Enter the glease, or complications that caused the death. shock, or heart favure. List only one cause on each line. Immediate Cause (Final disease or condition ulmonary

/Medical Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physlcian; The law requires that the death certificate be executed and signed by the attending physician be detached for use as the buria

Examiner icate has been si page 2 should b within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page

**Physician** 

Examiner

**Funeral** 

Director

show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important; or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exacinity or other traumatic event, the Medical Exacinity must be refulled at once.

**Physician** 

/Medical

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Director

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	resulting in death)	Due to (or as a conseq	Due to (or as a consequence of):									
iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	b. Due to (or as a conseq	Due to (or as a consequence of):									
/Medical Exar	Cause (Disease of Hijpi) that initiated events resulting in death) Last	Due to (or as a conseq	uence of):									
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		23d. Date of delivery Month Day Year									
ed by Pr	Part II. Other significant conditions con Chronic Obstruct		bacco use contribute to the cause of death?  es 2 No 3 Probably 4 Unknown									
Complet	Atrial Ebrillat	24a. Was an autopsy performed?	prior to completion of cause of									
Be (	25. Was case referred to medical	26. Place of Death (Check only one)										
	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)						
Medical Certification: To	27. Manner of Death 1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M 1 \[ \text{Yes} 2 \] No										
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street Cify or Town, Sta	and Number or Rural Route Number, ate)						
edical		rsician: To the best of my knowiner: On the basis of examination and manner stated.				e(s) and manner as stated. and place, and due to the cause(s)						
M	29b. Signature and title of certifier		2	29c. License number  DOUS3337		Pugust 7, 2004						

August 7, 2009

Suite 200 Reisterstown Mdz1136

DHMH 17 Rev 1/2001

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State

Registrar

Stree

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

07 2009

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3, Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** NGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** esapeak Ane UTUREC If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Numbe **Funeral** Months Days Hours 393-22-5248 1 □ M 2 🕱 F 10/9/1919 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show If item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Mydical Exeminar must be published at Anne Arundel Severna Park MD 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21146 USA death with 43 West McKinsey Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. be filed within 72 hours after ontal Hygiene.

dother than "natural", or iter 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Station Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Selin Eilers of Health and Ments item 27 is marked ၉ and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
520 Bayberry Drive , Severna Park, MD 21146 19a. Informant's Name/Relationship (Type. Print, Raddatž / Son Ronald R. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Southern WI Veterans
Cemetery 20c. Location - City or Town, State Union Grove, WI 8/10/2009 Pages 1 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 🖾 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral home Inc.
1501 East Fort Avenue, Baltimore, MD 21230 21. Signature of Funeral Service Licensee Dorota Marshall ouch Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition DAR UNG Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending plant in the second as 23c, if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☑ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 🗌 No 3 ☐ Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manna f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

30. Name

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hopkins Bayview Medical Baltimore N/A Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ M 2 🔀 F 82 212-30-4582 FEB. 26, 1927 MD. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County BALTIMORE ₩ Yes 2 No N/A MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 21224 337 HORNEL ST. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify. Specify. WHITE 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 9TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WALTER TERESKIEWICZ MARY STRINKOWSKY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 337 HORNEL ST., BALTIMORE, MARYLAND IRVIN ROBERT RZEPINNIK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 8/4/2009 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) STANISLAUS CEM. 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. Signature of Funeral Service Licensee 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part I Inter the deate, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final respiratory tallure disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumonia Due to (or as a consequence of) ongestive Due to (or as a consequence of) leliverv Day Year to the cause of death? Probably 4 Unknown autopsy findings available o completion of cause of 2 MNo pecify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral Director** 

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Completed

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**Funeral** 

**Director** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarinet must be notified at once.

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Hospital or Attending Physician: The law requires that the death certificate be executed

To the

Division of Vital Records, P.O. Box 68760,ダ

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completely filled in by the funeral director, page 2 should be detached for use as the burlar-th Medical Certification: To Be Completed by Physician/Medical Exc
completely filled in by the funeral director, page 2 should be detached for use as the burlal-to
within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician ar

Medical Certif

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1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifie

State Registrar

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Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ►No 9 □ Unknown		23d. Date of d Month								
þ	Part II. Other significant conditions	s contributing to death but not resulting in	n the underlying o	ause given în Part I.	23e. Did tobacco						
Completed					24a. Was an autopsy performed?						
Be (	25. Was case referred to medical			26. Place of Deat	th (Check only one)						
No E	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☑ Inpatient 2 ☐ ER/O	utpatient 3 🗆 D0	OA Other: 4 Nursing Ho	ome 5 Residence	6 ☐ Other (Sp					
-	27. Manner of Death			28c. Injury at	28d Describe how in	iury occurred					

Hospital: 1 🖾 Inpatient 2 🗆	ER/Outpatient	3 🗆 D	OA	Other: 4	☐ Nursing
28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	M	28c.	Injury at Work?	2 🗆 No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State) Let Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated.

29c, License number

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 07 2009 AUG

5 Pending investigation

6 ☐ Could not be

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Mary		rtment of F tificate of I			eg. No. 🤈 🗍	09 25260				
	Physicia	an a	1. Decedent's Name (First, Middle, Last)					2. Date of Dear Month	Day	3. Time of Death				
	/Medic		Melvin Robins			41 CO T	ultion of Dooth	07	30 0 4c. County of	9 0306 M				
	Examin	er	4a. Facility Name (If not institution, give:	/	CeHU		r Location of Death			MICA				
Ī	Funeral Director		5. Social Security Number 6. Sec	7. Age (In	yrs. last birthday) 7 0 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 4,	1938	9. Birthplace (State or Foreign Country) unk				
-	pur »		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits				
	Maryla f sho	lo	MD Worceste		Pocomol					1 □Yes 2₽ No				
	r 28a-	Director	10e. Street and Number			10f. Zip Code		Ţ.	10g. Citizen of W	/hat Country?				
	ath wit		720 10th Street				.851		USA					
	er des items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1    Yes 2  No	in U.S. 13.	Was Decedent of F f Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Pican, etc.)		e - American Indian, k, White, etc.				
036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the fredical Exacting or notified a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify.	black				
2-0	72 hor	eted	15. Decedent's Edu (Specify only highest grad	cation le completed)	(Give	dent's Usual Occup kind of work done	during most of work	king unk	16b. Kind of Bu	siness/Industry unk				
121	vithin ene. <b>than</b> "	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)							
<b>Q</b> 5	be filed within 72 ho ttal Hygiene. d other than "natul event, II. I edical	Be Completed	17. Father's Name (First, Middle, Last)			unk	18. Mother's Nam	ne (First, Middle,	Maiden Surnam	e) unk				
<u>/lar</u>	should be filed ind Mental Hygi marked other umatic event, II	To B												
Maryland 21215-0036	2 s rar rau		19a. Informant's Name/Relationship (T) Penninsula Region				and Number or Ru			State, Zip Code) 21801				
a)	1 and Health tem 27 other ti	1	20a. Method of Disposition		20b. Place of Dispo			Date		City or Town, State				
altimore,	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☑ Other (Specify)	Removal from State	cemetery, crer	natory or other pla	(6)							
Balti	permit. Pages Department of Important: If it any Injury or o		21. Signalure of Funeral Service lights Konald	Jad Direc					Baltimo	ore Street				
			Baltimore, MD 21201  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Bet Onset and I											
	Physician	1	Immediate Cause (Final disease or condition	a. Ascm						Unset and Death				
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):									
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8760,	ficate be executed physician and s the burial-transit	a E	resulting in death) Last Due to (or as a consequence of):											
	tificate g phys as the	edical		d										
30X	leath certific attending p	an/M	23b. was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		☐ Ectopic pregnan	су			te of delivery onth Day Year				
O. Box	at the dea by the at tached fo	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death 5[	Other (specify)								
σ.	res that the signed by be detacted	y Ph	Part II. Other significant conditions co	entributing to death but n	ot resulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use cont	ribute to the cause of death?				
Vital Records,	w requires s been sign should be	ed by	habelos Hellit	20				1 🗆 🗅	/es 2□No	3 Probably 4 Unknown				
ဝ၁ခ	e law re has be je 2 sho	Completed						24a. Was autop	osy	Were autopsy findings available prior to completion of cause of				
ᄪ	iclan: The I certificate ha ector, page							1 □ Yes	2-No	death? 1 □ Yes 2 □ No				
Z.	siclar s certif irector	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No	Hospital:	2 ☐ ER/Outpatie	nt 3 □ DOA Ot	bor:	ath (Check onlog Home 5 ☐ Resid		ner (Specify)				
0	iding Physiclan: th. After this certifications funeral director,	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Ye	28b. Time o				now injury occur					
sior	eath. or: Af	catic	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 1	]Yes 2 □No			D. / D. / Mark				
Division of	or Attendation after deation Director:	Certification: To	4 Homicide determined	28e. Place of Injury building, etc. (	<ul> <li>At home, farm, st Specify)</li> </ul>	reet, factory, office		City or To	Street and Numb vn, State)	ber or Rural Route Number,				
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only one) 1 Certifying Physics Certifying Physics 2 Medical Example (Check only one)	ysician: To the best of nather: On the basis of example and manner stated	camination and/or in	th occurred at the nvestigation, in my	time, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as stated. and due to the cause(s)				
	To the within To the comple	Me	29b. Signature and title of certifier			_	ise number			ed (Month, Day, Year)				
			1 Herry			D63	199		July 3	30,2009				
			30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	Print)	h en/	Luga	20-0	30, 2009 21801				
	Sta	ate	31. Date filed (Month, Day, Year)	7-11-51-11-11	Signature	OUL 31	· 2/1/13	Sistery	me.	0.001				
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		,	State of Maryland / Department of Health and Me 1 - State Registrar  State of Maryland / Department of Health and Me Certificate of Death	ental Hygier Reg. I	2000	25261	
	Physici	an	EL 17 VDEMA		Day Year	3. Time of Death 7:30 PM	
	/Medio		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		1, 2009 4c. County of Death		
,d			GOLDEN LIVING NURSING FACILITY WESTMINSTER			ROLL	
	Funeral Director		214-26-9256 1 M 2 F 77 Yrs. Months Days Hours Min.	3. Date of Birth (Month, Day, Yea 8 – 15 – 19	31 MAI	place (State or Foreign Intry) RYLAND	
	ryland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
	he Ma 28a-f s	ecto	MD BALTIMORE MIDDLE RIVER	10-	Oiline at Mile at One	1 ☐ Yes X☐ No	
	ath with the 23a or 2 ust be n	Funeral Director	10e. Street and Number 44 HEBRON AVENUE 10f. Zip Code 21220		Citizen of What Cou		
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, If a Pudical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married  2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rie If Yes, specify Cuban, Mexican, Puerto Rie If Yes, Sive Year or Dates:	ify Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: WI	ican Indian, , etc. HITE	
21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b.	Kind of Business/I	·	
	filed within Hygiene. other than '		8 HOMEMAKER	(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	OWN HOL	)ME	
Maryland	ild be file fental Hy rked oth	To Be	17. Father's Name (First, Middle, Last)  GEORGE FREDERICK BARBAR.			ITTER)	
	and 2 should I safth and Men 1.27 is marke er traumatic		19a. Informant's Name/Relationship (Type. Print)  CHRISTIAN STIHEL/SON  19b. Mailing Address (Street and Number or Rural III)  869 GAMING SQUARE	Route Number, Cit HAMPSTE		21074	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Onation 5  Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  HOLY REDEEMER CEM 8-8-0		Location - City or T		
<b>3altir</b>	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVA	CH/ROSE	DALE FUI	NERAL HOME	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	ROSEDA respiratory arrest.		21237 Approximate	
	Physician /Medical Examiner	ıer	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or is a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	May D	Eseise	Interval Between Onset and Death	
€8760,€£	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			25/1	
O. Box	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₽ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown		23d. Date of deli Month	very Day Year	
rds, P.	w requires that been signed be should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco		the cause of death?	
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Ž	S S =	o Be	examiner?		6 ☐ Other (Spec	cify)	
	ding Phy h. After thi funeral	on: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?	Bd. Describe how in	•		
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, farm, street, factory, office 3e. Place of Injury - At home, street, factory, street, factory, street, facto	Bf. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,	
_	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.  29a. Certifier (Check only one)				
	To the vithin To the comp	Me	29b. Signature and title of certifier  29c. License number	29d.	Date signed (Month	n, Day, Year)	
•	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	n d	100/2	007	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	nma	hee ten	W 41102	
	Registr		AUG 07 2009 Serve B. Market				

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		•	For State Registrar				cate of l				g. No.	17 474	.04	
			Decedent's Name (First, Middle)	le, Last)					2. Date	e of Death		3. Time of D	eath	
	Physicia /Medic		Carl A. Simo	es					Augu		,2009	11:15P	М	
A. S.	Examin		4a. Facility Name (If not institutio			4b.	City, Town, or				4c. County of			
			3824 Proctor  5. Social Security Number		e (In yrs. last birti	hday) If U	NOC1 nder 1 Year	tingh   If Under	24 Hrs. 8 Date	e of Birth	Birth 9. Birthplace (State or Foreign			
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	p		Usual Residence of Decedent		40 - Cit Town	au Lacation						10d. Inside City		
	arylar show	'n		nellas	10c. City, Town		Pine	11as	Park			1X☐Yes 2		
	the M	Director	Pa Schuy	<del>LK111-</del>	-	Mahan 10	<del>3 y</del> f, Zip Code		00701	10	g. Citizen of Wha	at Country?		
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It has a state of the than "natural", or items 23a or 28a-f show item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is more facilities of the traumatic event, it is more facilities.	al Dir	10e. Street and Number 34248 Canal 711 E. Mahan	Drive <del>ov Avenue</del>			1794	<del>48</del>	33781		US	SA		
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was E	ecedent of H	lispanic Ori	igin? (Specify Ye n, Puerto Rican,	s or No-		American Indian, White, etc.		
9	or ite		1 Never Married 2 Mai	ried 1∭XYes 2 ☐ I If Yes, Give	No		es 2X No	Specify:		310.7	Specify:	White		
21215-0036	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:	160	Dogodont's	Heurel Occurs	ation			16b. Kind of Busin			
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Maryland	2 should be to and Mental Is marked of aumaric eve	To	Manuel Simoes						Virgin	ia Fl	amini			
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e, 7	s 1 and 2 of Health item 27 I		Thomas Simoes 20a. Method of Disposition	s Broth		3824 ]	Procto	r Lan	e Nott		am, Md.	21236 ty or Town, State		
nor	ages nt of it t; If ite		1 XBurial 2 ☐ Cremation		20b. Place of cemeter.			i	8-8-2009			wp., Pa.		
Baltimore,	permit. Pages Department of Important: If ite any injury or of once.		4 □ Donation 5 □ Other (a		bacte	-	ne and Addre				Funeral		-	
Ba	permi Depar Impor any ir	1		////		9	705 Be	lair 1			ham, Md.			
r.			23a. Part1. Enter the disease, or heart failure. Lie	or complications that caused	the death. Do r	not enter the	mode of dyir	ng, such as	s cardiac or respi	ratory arr	st,	Approximate Interval Betw	veen	
	Physician	P	Immediate Cause (Final disease or condition										eath	
	/Medical	resulting in death)  Due to (or as a consequence of):												
	Examiner		Sequentially list conditions,	. В		0								
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Вох	th cer tendir r use	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 □ Ect	opic pregnanc	су			23d. Date Mont		'ear	
O.E	e dea the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)					111011				
۵.	that the		Part II, Other significant condit	ions contributing to death b	ut not resulting in	the underly	ing cause giv	en in Part	I. 23	Be. Did tol	pacco use contrib	oute to the cause of de	eath?	
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ita		O	25. Was case referred to medic	al				26. Plac	e of Death (Che		-			
of Vital Records,	Physician; this certific ral director, I	To B	examiner? 1 ☐ Yes 2 ☐ Vo		ent 2 ER/Ou	tpatient 3	□ DOA Oth	ner: 4□N	lursing Home 5	Reside	ence 6 Other	(Specify) Prot	ners	
	ing P	ü.	27. Manner of Death  1 Natural 5 □ Pend			Fime of njury	28c. Inju Wor	rk?	_	escribe he	ow injury occurred		suse	
sio	Attending or death. ector: After by the funer	icati	3 Suicide 6 Could		ury - At home, fa	rm street f		Yes 2	-	cation (S	treet and Number	r or Rural Route Numi	her	
Division	l or A after o Direc	Certification:	4 ☐ Homicide deter	mined building, e	c. (Specify)	iiii, 30'00', 1	actory, office			ty or Town		or raid riodic runn	301,	
_	Hospital 24 hours a Funeral Detely filled	a C	29a. Certifier Certify	ing Physician: To the best	of my knowledge	e, death occ	urred at the t	ime, date a	and place, and du	e to the o	ause(s) and mar	nner as stated.		
7	1 2 1 2	edical	(Check only 2☐, Medic one)	Examiner: On the basis and manner st		ıd/or investi	gation, in my	opinion, de	eath occurred at t	he time, c	iate and place, ar	nd due to the cause(s)	1	
•	<b>To the</b> within 2 <b>To the</b> сощріє	ž	29b. Signature and the of certif	er \	1 A		29c. Licens	se number	< 7	1	9d. Date signed	(Month, Day, Year)	00	
			<b>P</b> /\ \/ \	1	NV_		147 A)	1715	, ) (	A	ugust,	4 100	27	
			30. Name and address of perso	n who completed cause of	death (Item 23a)	(Type, Print	1	1	L. D'	14.	M D	171747	,	
	Sta	ate	31. Date filed (Month, Day, Yea	r) 32. Regist	rar's Signature	PLOO	C. Wo	71	1.16 Do	11110	وريد إ	14-01		
	Regist		AHC A 7 9	my lesse	A. A.	arker	P	1						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 9:53am Elizabeth Stinchcomb Lois August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll Carroll Hospice Dove House Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 F 95 July 3 1914 MD 215-40-4804 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 X Yes 2 No Sykesville Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 7331 Springfield Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 □No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐Yes 2√√ No Specify: 3 ♥ Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Jenny Henry Joseph Webster Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 7331 Springfield Ave., Sykesville, MD 21784 Daniel Stinchcomb (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 D Burial 2 □ Cremation 3 □ Removal from State Springfield Cemetery 8-8-09 Svkesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Day Hayer Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence Due to for as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Department of Health a Important: If item 27 is any injury or other trau once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

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?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be ruithed at

Pages 1 and 2 should be filed within 72 hours after death with

and Mental Hygiene.

altimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and itely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Be Completed Certification: To

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 ☑No 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2-☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 2+1NO 1 ☐ Yes 1 ∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **☑** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) and manner stated. 29b. Signature and title of certifig License number

e Funeral Dire

within 2

completely

State Registrar

1 HOMA eNTO 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUSINESS CENTER DR. 32. Registrar's Signature

DHMH 17 Rev 1/2001

REISTERSTOWN, MD 21136

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Lest) PM Month 2009 **Physician** Vie /Medical 4b. City, Town, or Location of Death Fecility Neme (If not institution, give street end number, 4c. County of Death Examiner Health DUITIMO PE If Under 24 Hrs. 8 Date of Bi 8 enab. Cen 7. Age (In yrs. last birthday) Ter If Under 8. Date of Birth 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days 1□M 200 F 212-30-879 Usuel Residence of Decedent Hours Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 12. Was Decedent Ever in U.S. Armed Forces? 2120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be 19a. Informant's Name/Relationship (Type, Print) (S) Ster) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) lamon TO ber 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20e. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2009 4 □ Donetion 5 □ Other (Specify) 10n 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ph L. Russ Funeral Home, P.A. W. North Ave, Balto, Md. 21216 Joseph 2222 Pant/Enter the disease, or complications that excised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shorts, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as e consequence of) Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 2 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 Deno 1 ☐ Yes 2 No 1 🗆 Yes certificata Director: After this certific d in by the funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Certification: To 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpetient 3□ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation Naturel 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Director: Af 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Pay, Year) 29c. License number 29b. Signature and title of certifie ender

**DHMH 16 Rev 6/95** 

State Registrar 5601

Loch 31. Dete filed (Month, Day, Year) Bal

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kayer

Blvd

32. Registrar's Signature

Sireesh

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician /Medical Month Year 200 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 1) | Min. | Jan 34 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 191-48-486 1 - M 2 7 F 52 Yrs Director ORK, Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. Stati 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at A 1 Yes 2 No Director ORK Allastown 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? Ь items 23a 7313 1. S. B Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 11. Marital Status Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 XNo Specify à Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be is marked 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 17313 20a. Method of Disposition 20b. Place 20c. Location - City of Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility 10W Part 1. There the disease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death Live birth 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No page 2 should be detached for Month Day Year Pregnant at time of death 5 Other (specify) Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 2 🗌 No 2 No Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA မ 5  $\square$  Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in a stated. the Hospital 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, \*\*

		1 - State Amend #/ per In g894 8/31/09 Ger	tificate of Death	Reg	J. No.						
Discoulation in the second		Decedent's Name (First, Middle, Last)		2. Date of Death							
Physicia /Medic		BARNARD FRANKLINI	SELLERS	JOLY Z		0145 M					
Examin		4a. Facility Name (If not institution, give street and number) 95/2 NIGHT-SONG LANE	4b. City, Town, or Location of Death COLUMBIB		4c. County of Death  How M	eD.					
Funeral Director		5. Focial Sergity 19985 6. Sex 12 F 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	(ear) 9. Birthp Cour NEW	lace (State or Foreign try)					
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with the Maryland a or 28a-f show	tor	10a. State 10b. County 10c. City, Town or Loc	um biA		,	0d. Inside City Limits 1					
with the	I Director	10e. Street and Number 9512 NIGHTSONG LANE	10f. Zip Code 2 1046	109	g. Citizen of What Cour						
ms 2;	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	an Indian,					
urs after al", or ite	by	1 Never Married 2 Married 1 Tyes 2 No	f Yes, specify Cuban, Mexican, Puerto ☐ Yes 2 XNo Specify:	nicari, etc.)	Specify: U	4175					
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ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprinter must be notified at	To Be C	17. Father's Name (First, Middle, Last)  MILTON SELLERS	18. Mother's Name	(First, Middle, Ma Wil	onoku	1					
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permit. Pages Department of Important; If i any Injury or once.			. Name and Address of Facility Hou	well Fo	NERWL	Home,					
9 9 E # 9		Called Bones In 10	0220 Guiltong	Rd, VI	SSU PMO	20794					
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certificate ding phys se as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv						
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v require been sig should b				1 ☐ Yes	s 2 No 3 Pro	bably 4 Unknown					
law ri nas be	Completed		·	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of					
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sician certifi rector	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death								
Physer this eral di	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of	1 3 DOA 4 D Nursing Ho	28d. Describe how	nce 6 □ Other <i>(Speci</i> v injury occurred	<i>Ty)</i>					
nding ath. r: Afte e fune	ation	i Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No								
l or Atte after dea Director	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rur State)	al Route Number,					
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.									
orthe	Mec	29h Signature and title of certifier	29c. License number		ld. Date signed (Month						
		Physicians	D 006270	14	丁レレア 3	2009					
(7)		30. Name and address of person who completed cause of death (Item 23a) (Type, 3290 No Ridge Road, Swit	Print)	Gty.	MD 210	43.					
Sta	ate			3/							
Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	als								
/IH 17 Rev 1/2	001	NOU									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician ByRON SHIPMAN 80 03 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HHANHE 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months **Director** 244-56-3738 No. Carolina 71 May 25, 1938 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, the "Modical Evaninar must be natified at 90Re. 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 1 □Yes Ž□No Funeral Director Randallstown Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5107 Old Court Road 21133 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed by **Black** Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Electric Forklift Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maggie Shipman Cornelius Shipman ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5107 Old Court Road Randallstown, Maryland 21133 Diretta Shipman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/10/09 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 ont enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the diseas r complications that caused the death. Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Luna Cancer /Medical Due to (or consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burlal-transi Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋛ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. BUCRNP 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R125808 atv, Samp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8. He des Perster

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle 3. Time of Death Month **Physician** /Medical County of Death Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 9. Birthplace (State or Fol Country) f Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** 1 M 2 F Days Min. Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. Count show r than "natural", or Items 23a or 28a-f sho 1 ⊠Yes 2 No Director BALTIMORE TIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 107 SA Funeral ircle filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status □Yes 2□Mo 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft.
Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "natural", or I any injury or other traumatic avant. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NA  $\mathcal{N}$ 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Moleke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore mo 21229 tany Wimb Circ Le 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -31-09 Bo-Itmore 4 ☐ Donation 5 ☐ Other (Specify) ew Ashton Funeral 22. Name and Address of Facility 21. Signature of Europral Service Road 021223 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 mu /Medicai Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) Ö the detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 2 should been 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 □No 1 □ Yes 2 1100 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 24 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending 1 □Yes 2 □No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examine and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Registrar

State

31. Date tijed (Month, Day, Year) AUG 0 6 2009 32. Registrar's Signature

Marne and address of person who completed cause of death (Item 23a) (Type, Print)

			1 - For Stete Registrer	State of Maryland	•	ent of Health and ate of Death	d Mental Hy	giene	nng	25269
· ·	Physici	an	Decedent's Name (First, Middle, Last,	ota Sh	iolds		2. Date of De Month		Year	3. Time of Death
es.	/Medic Examin	al	4a. Facility Name (If not institution, give  15. Social Security Number 6. Security Number 6. Security Number 15.	dical Cont	st birthday) If Unit		eath  Hrs. 8. Date of Bin. (Month, Di	rth ay, Year)	ounty of Death OHM  9. Birth Cou	Ve Cttg place (State or Fordign intry)
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27273-UU36  within 72 hours after death with the Maryland jiene. rithan "natural", or Itams 23a or 28a-f show the Madical Examiner out be notified at	<b>Director</b>	MD BALTIM  10e. Street and Number	ORE BAL	TIMORE 101.	Zip Code		10g. Citize	en of What Cou	1 ☐¥6s 2 ☐ No intry?	
	by Funeral Director	10.7 Thomas Gu  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No It Yes, Give Year or Dates:	13. Was De If Yes, s	21229 cedent of Hispanic Origin? pecify Cuban, Mexican, Pu 22No Specify:	(Specify Yes or No Jerto Rican, etc.)	0- 14	LS 1A  I. Race - Amer Black, White		
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ryland	id be filed ental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last)  Jamae Mole  19a. Informant's Name/Relationship (Tr		ds		Name (First, Middle	quit	a W	in 65
re, Mc 1 and 2 Health a tem 27 la	Health a tem 27 la		T, FFany W, m b S  20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	mother 200. Pla	107 The	nage Guide	Date -31-09	cle	0	ore MD 21229
Balti	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licens	90	22. Name	and Address of Facility	Bradley	-1951		RIBBA
4 4	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	ications that caused the death ne cause on each line.  Due to (or as a consequence of the consequence)  Due to (or as a consequence of the consequ	n Deli	very			enbou	Approximate Interval Between Onset and Death  32 MIN  - /3day-
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O. Box 68	The law requires that the death certific: te hes been signed by the attending pl page 2 should be delached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. It yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3 □Ectopia	c pregnancy (specify)		23	3d. Date ot deli Month	very Day Year
rds, P.	w requires that I been signed by should be deta	þ	Part II. Other significant conditions co	ntributing to death but not resul	Iting in the underlyin	ig cause given in Part I.		tobacco use		the cause of death?
Vital Records,		Completed					per 1 🗆 Yes	2 No	death?	topsy findings available completion of cause of
	ysician ils certif directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☑Inpatient 2 ☐ E	ER/Outpatient 3	Other	Death (Check only ng Home 5 Res		Other (Spec	nfy)
Division of	Jing J After funer		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe			
DIX	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	)		City or To	own, State)		ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Dedical Exami	sicien: To the best of my know iner: On the basis of examination and manner stated.	vledge, death occur on and/or investigat	red at the time, date and p ion, in my opinion, death o	lace, and due to the occurred at the time	a cause(s) a a, date and p	and manner as place, and due	stated. to the cause(s)
ı	To the To the Comp	ž	29b. Signature and title of certifier	1/1		29c. License number	7.1	29d. Date	signed (Month	n, Day, Year)
	d		30 Name and address of person who co		23a) (Type, Print)	94417643 ul S7, Bo	JM .	1/	2/2	W7
4 1	Sta		31. Date filed (Month, Day, Year)	MD 30/ S 32. Registrar's Signatu	ure	11 St, 50	(TINO/E)	-4b	XUX	
1	Regist	rar	AUC 0 6 2000	Maria 8. A	arked					

# Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760

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		Registrar  1. Decedent's Name	e (First, Middi	le, Last)				007	imeate or	Deali	2. Date of De		401	14	3. Time of Death	
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and		Usual Residence of Decedent           10a. State         10b. County         10c. City, To						wn or Loc	cation	-				1	0d. Inside City Limits	
Maryi a-f sho	ţ	Maryland	Worc	estei	2		0cea	an Pi	nes				1 <b>X</b> Yes 2□No			
or 28%	Director	10e. Street and Nur							10f. Zip Code	1011		10g. Citizen of What Country?				
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be filed within 72 hours after death with the Maryland ntal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Evaninar must be notified at	Be	17. Father's Name (First, Middle, Last) Harry S. Jones								18. Mother's Nam	ne (First, Middle,		Surname)			
should nd Mer marke matic	၉	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta  37 Moonshell Drive, Berlin, Maryland 2											ate. Zin	(Code)		
and 2 sealth ar						ter										
ges 1 at of He it item		20a. Method of Dis 1 Burial 2		3 □ Rer	noval from S	State	otoma	tery crea	sition (Name of natory Methoda ed Methoda	Augu	st 10,	20c. Loc		-	wn, State C, Maryland	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantical must be notified at once.		4 □ Donation  21. Signature of Fu				,	Church	n Cem	etery	200						
Dep lmp any		My	relette	Ban	ment.	M01	305	30	bert A. 00 West Mc	Pumphrey ontgomery Av	runera. venue, Roc	L Hom kville	e/Roo	land	ille, Inc. 120850-2805	
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death certificate to attending physical for use as the b	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy										of dollar	2004			
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s been si should b	ete					_					24a. Was		24b. We	re auto	psy findings available	
The law ate has page 2 s	Completed										auto perfo 1 □ Yes	psy ormed? 2 X No	dea	ith?	mpletion of cause of 2 □ No	
cian: certific ector,	Be	25. Was case refer examiner?	red to medica	_	-14-1					26. Place of Dea					7	
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r Atte ter dea irector	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern		28e. Place buildir	of Injury	- At home, Specify)	farm, stre	eet, factory, office		28f. Location ( City or To	Street and wn, State)	i Number	or Rura	al Route Number,	
pital o		29a. Certifier	1 Certifvii	na Physia	rian: To the	heet of n	ny knowler	dae death	a occurred at the t	ime, date and place	and due to the	causa(s)	and man	201 20 9	ctated	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check only one)	2 Medical	Examine	r: On the ba	asis of ex	amination	and/or in	vestigation, in my	opinion, death occu	irred at the time	, date and	place, an	d due to	o the cause(s)	
To the Common Co	Š	29b. Signature and	title of certifie	er					29c. Licens	مسر، م <u>ب</u>		- 4			Day, Year)	
		30. Name and addr	ress of norman	who com	nleted cave	e of done	h (Item 20	a) (Tuno	Print)	108465	rlin M	Aug	ust	2,	2009	
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Registra	il e	A1	IG 072	2009	Dens	un	A.	goar	Karin							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Jeath Mental Hygiene Certificate of Death

Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 **Physician** Betty W. Smith 2:30 P M August 5, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1918 1 □ M 2 😾 F Months Days Hours Min. Mary land 91 219-09-3016 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 K No Director Maryland Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 719 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items, 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 No White Specify à Specify: 3 → Widowed 4 Divorced Year or Dates: than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Hand Mental Mental Mental Hand Mental Caspar A. Wagner Helen T. Huppmann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any Injury or other traun 13109 Sanfield Road; Baldwin, Maryland 21013 Amy\_Roberts Great Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Atlantic Crematory 8/7/2009 Glen Burnie, Maryland 4 □ Oonation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signalure of Funeral Service I 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) AMPLE A TITUS /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last VED BY MEDICAL EXAMINER Due to (or as a consequence or) Examine and burial-trar CERTIFICATION Due to (or as a consequence of): physician Physician/Medical the as attending 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed dehy distion 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has page 2: autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 X Yes 2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury p • Unknown M 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; After the Hospital or Attending 5 Pending investigation 1. Natural death. 07/28/09 Subject fell. 1 ☐ Yes 2 K No 2 X Accident after death Director: in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 719 Maiden Choice Lane, HR635, Catonsville, MD 4 Homicide Home Funeral D hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier cal 24

To the I within 2 To the I

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated

in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

No

milletan

29d. Date signed (Month, Day, Year)

Chone Care Calfundle

1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 2009 **Physician** 2.31 A M **ABRAHAM** SCHMELL AUGUST 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE N/A BAUTIMORE OF CITY SINAL HOSPITAL If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 01/19/1920 5. Social Security Number 7. Age (In yrs. last birthday) Funeral **₩X**M 2□F POLAND 114-07-4806 89 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, I'm I'm fiel Everting in ust to motified at 1X□Yes 2 □ No Funeral Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3700 CLARKS LANE 21215 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married WHITE 1 □Yes 2X No Specify: Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER BAKERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be es 1 and 2 should be f of Health and Mental NATHAN SCHMELL **DEBRA** UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRWIN SCHMELL / SON 3813 MENLO\_DRIVE, BALTIMORE, MD 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Department of Important: If It any injury or o t Burial 2 ☐ Cremation 3 ☐ Removal from State SHEARITH ISRAEL CONG 08/06/2009 4 Donation 5 Dother (Specify) BALTIMORE. MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN RD., PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Day 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 HInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE PULMONARY DISE ASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown INTERSTITIAL LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate ueaun? 1 □ Yes 2 🙇 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number LB-000 MASS AUGUST, 06, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE RAJEEV GUPTA, MBBS SINAL HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	or maryland / Dep	ertificate of D		Reg. No		05070		
			Decedent's Name (First, Middle, Last)				Date of Death Month Da	<del>2003</del>	3. Time-of Death		
	Physici /Medic		JACK SPET	SER			n 0	509	10:20AM		
	Examin	er	4a. Facility Name (If not institution, give street and		4b. City, Town, or L		40	. County of Death	DE		
			CHAPEL HILL NURSING  5. Social Security Number 6. Sex	HOME  7. Age (In yrs. last birthda		ALLSTOWN If Under 24 Hrs.   8.	Date of Birth	BALTIMO	iono (Stato or Faraire		
	Funeral Director		127-36-0363 Usual Residence of Decedent		Months Days	Hours Min. 0	(Month Day Year 8/04/1946	Coun	GERMANY		
	land ow	}	10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits		
	Mary a-f sh	iç	MD BALTIMORE	E	BALTIMORE				1 □ Yes 2X □ No		
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Coun	-		
	ath w	ra	4405 SUMMER GRAPE RO	AD	212			USA			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Modicel Examiner cast Le rodified at	by Funeral	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. d Forces? es 2 1 10 No , Give or Dates:	3. Was Decedent of His If Yes, specify Cuban 1 □ Yes 2 No	panic Origin? (Specify , Mexican, Puerto Rica Specify:	/ Yes or No- an, etc.)	Black, White,	American Indian, White, etc. WHITE		
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ary.	d 2 should be th and Mental 7 is marked of traumatic eve	ř	19a. Informant's Name/Relationship (Type. Print)	, 19b. Ma	ailing Address (Street ar	nd Number or Rural R	oute Number, City	or Town, State, Zip	Code)		
	ガモアは		BEVERLY SPEISER/WIFE	440	5 SUMMER G	RAPE ROAD,	BALTIMO	RE, MD 2	1208		
ore	S to E		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal for	20b. Place of Dis	sposition (Name of rematory or other place	) Date	20c. l	ocation - City or To	wn, State		
Ĕ	Pag men in in		4 Donation 5 □ Other (Specify)	RK 08/06/2		ANDALLSTO					
Baltimore,	permit. Page Department Important: I any Injury o		21. Signatur of Funeral Servic Licence	of Facility SOL ERSTOWN RD		N & BROS. VILLE, MD					
Ε			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death. Do not on each line.	enter the mode of dying	, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death		
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	outed d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	TRIAL F	LBRILL.	ATION					
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.O. Box	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	Physician/N	in the past 12 months?	ive birth 2 Tetal death	3  Ectopic pregnancy 5 Other (specify)			23d. Date of delive	ery Day Year		
ď.	res that signed b	by Pi	Part II. Other significant conditions contributing	to death but not resulting in the	e underlying cause give	n in Part I.	23e. Did tobacco	use contribute to t	he cause of death?		
ğ	w require been signature should b	edt					1 ☐ Yes	2 □ No 3 □ Prol	bably 4 🕅 Unknown		
Vital Records,	ian: The law re rtificate has be tor, page 2 sho	Completed					24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of		
/ita	Physician: r this certific ral director, I	Be (	25. Was case referred to medical examiner?		l out-	26. Place of Death (C	Check only one)				
of	Phys this al dir	은		1 ☐ Inpatient 2 ☐ ER/Outpa Date of Injury 28b. Time		4 K Nursing Home	5 Residence		fy)		
G	ding h. After funer	tion	1 X Natural 5 Pending 2 Accident investigation	Month, Day, Year)	y Work?		i. Describe now inj	ary occurred			
Division	al or Attending Phy: s after death. Il Director: After this ed in by the funeral di	Certification:	3 Suicide 6 Could not be determined 28e. F	lace of Injury - At home, farm, uilding, etc. (Specify)	street, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Run te)	al Route Number,		
O,	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	(Check only 2 Medical Examiner: On t	o the best of my knowledge, do he basis of examination and/o manner stated.	eath occurred at the time ir investigation, in my op	ne, date and place, and pinion, death occurred	d due to the cause at the time, date a	(s) and manner as and place, and due t	stated. o the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License	number	29d. E	ate signed (Month,	Day, Year)		
			ap, conp		RIS	35808		8/5/00	7		
			30. Name and address of person who completed	cause of death (Item 23a) (Typ	pe, Print)		D		110		
			Anne L. Villanue U. 31. Date filed (Month, Day, Year)	4 CRNP '25	MAIN ST	· , STE 2	SO, KEIS	TERSTO	EN MD SIB		
e.	Sta Registr		AUG 07 2009	22. Registrar's Sgnature	Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#4a&24a, perPHYS, G894, 877,09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Bay Year Physician UCKEY 1:30 AM 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 4a. Facility Name (If not institution, give a rest and number) timore If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Unde 5. Social Security Number 7 Age (In yrs, last birthday) Sex Funeral Year Months Davs 1 M 2 F <del>331-34-4768</del> Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State show injury or other traumatic event, the fluctional Examinar must be notified at 1 Y96 2 No Director 28a-f 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 items 23a MUUSO 21D Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?, 1 \( \text{Yes} \) 2 Who If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Bac "natural", or Specify Completed by 3 Widowed Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the the stand injury or other traumatic event, the the Elementary/Secondary (0-12) College (1-4or 5+) Employed QUOV 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Himore amala daughter DOOWSOO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) on 21. Signatur f Funeral Service Lic 22. Name and Address Balto MD 2120 4600 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner -Arte mary if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-tran and Due to (of as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Day Year 5 ☐ Other (specify) signed by the a I∐Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 □ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 (Matural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIVISION 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** М W GUST 2001 /Medical Facility Name (If not institution, give street and number) of Death Examiner with more dailstown Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, (In yrs. last birthday If Under 1 **Funeral** Fountry) nia 3 Director Usual Residence of Decedent 10b. County Town or Location 10d. Inside City Limits 10a. State 10c. City, 28a-f show is marked other than "natural", or Items 23a or 28a-f sho aumatic event, the Madical Extender must be notified at 1 Nes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Never Married 2 Married Baltimore, Maryland 21215-0036 200 No 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) or other traumatic event, 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other tran-20b. Place of Disposition (Name of cemetery, crematory or other p Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. SignatOre of Funeral Service Licensee 140 2120 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit Box 68760, 4 and Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Day isigned by the a d be detached for 5 ☐ Other (specify) 0 9 Unknown 9 Hlnknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown icate has been si , page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate Division of Vital 1 ☐ Yes 2 📜 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the Funeral Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 To the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 28355MITH Avenue Sule 203 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

AUG 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 6:30 P Barbara Ann Trimmer Jul 30, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard 6737 Pine Dr. Columbia Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F Yrs Wish. Director 220-80-2940 Nov 25, 1957 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Mexical Examiltar must be rediffed at 1 Yes 2 No Director MD Howard Columbia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21046 6737 Pine Dr. U.S.A Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status within 72 hours after 1 □Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: White 4 Divorced 3 Widowed Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be f permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ev Ellen Catherine Kerwin Kenneth James Gosnell ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6737 Pine Dr. Columbia, MD 21046 Ellen Gosnell Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State ELLICOTT CITY, MD 8/3/0 Donation 5 ☐ Other (Specify) SHED HEZD Com 1 22. Name and Address of Facility 21. Signar re di Funeral pervice Li pisee Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy 5 Other (specify) P.O. the 9 Unknow signed by t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 8 Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Chendler MD andace

Registrar
DHMH 17 Rev 1/2001

State

Back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

07 2009

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Division or Vital Records, P.O. Box 68760, Op	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director page 2 should be detached for use as the burial-transit

			For State Registrar	State of Maryland	-	rtment of F Fificate of I			giene Reg. No. 🖊	009	2527	-		
	Physicia		1. Decedent's Name (First, Middle, Last)	WALTE	25			2. Date of Dea Month AUG US7	Day	Year 2009	3. Time of Death	1		
	/Medic Examin	-	4a. Facility Name (If not institution, give str				r Location of Death			nty of Death		_		
			FRANKLIN WOODS  5. Social Security Number 6. Sex	FACILITY  7. Age (In yrs. las	st birthdav)	RC If Under 1 Year	SSVILLE If Under 24 Hrs.	8 Date of Birt	rth ay, Year)  BALTIMORE  9. Birthplace (State or Foreign Country)					
í	Funeral Director		219-16-8254 <sup>180</sup>		34 Yrs.	Months Days	Hours Min.	(Month, Day 1 - 27 -	1925		YLAND	_		
	Maryland a-f show ified at	tor	Usual Residence of Decedent  10a. State MD BALT	IMORE 10c. City,	Town or Loc	ation	ROSED	ALE		10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No			
	th with the 23a or 28a ast be not	Funeral Director	10e. Street and Number 6207 SCRANTON I	ROAD		10f. Zip Code	21237		Citizen of What Country? U.S.A.					
	s 1 and 2 should be filed within 72 hours after death with the Maryland feelanth and Mental Hygiene. The feelanth and Mental Hygiene after 15 marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Styses 2 □ No If Yes, Give Year or Dates: WWII		/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spe	Race - America Black, White, e		_		
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7 7	withir jiene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		ELIVERY			Billo	EL				
ומות	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mematic event e	To Be C	17. Father's Name (First, Middle, Last) WILLIAM E.	. WALTER	RS		18. Mother's Nam	e (First, Middle,		ame) ATTEE	)			
Mai	and 2 shore ealth and N n 27 Is ma		19a. Informant's Name/Relationship (Type ROSE HEATH/SIST				and Number or Rul			vn, State, Zip LE , Mi				
ב ב	permit. Pages 1 and 3 Department of Health Important: if item 27 any injury or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			ition (Name of atory or other pla-		Date - 0.9		n - City or To				
	permit. P Departme Importan any injur once.		21. Signature of Funeral Service Licensee		22.	Name and Addre	i i	ACH/RO		E FUNI	ERAL HOM 21237	I		
	- Age		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	eations that caused the death.	Do not ente	r the mode of dyi	ng, such as cardiac	or respiratory a			Approximate Interval Between Onset and Death	_		
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	METASTAT	IC	LUNG	CAN	CEL				_		
	Examiner	J.	Sequentially list conditions, b.	Due to (or as a conseque	ence of):							_		
р	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.											
500	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a conseque	ence of):							_		
O. DOA GO	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome pf pregnan 1 ☐ Live birth 2 ☐ Fetal ( 4 ☐ Pregnant at time of dea	death 3□	Ectopic pregnanc Other (specify)	y			Date of delive	ery Day Year			
Oldo, F.	ires that t signed by d be detac	by	Part II. Other significant conditions cont		ting in the un	derlying cause giv	ven in Part I.			ontribute to th	he cause of death?	'n		
	e law requas been e 2 shoul	Completed						24a. Was	psy	4b. Were auto	opsy findings availabl mpletion of cause of	ie		
La l	an: The tificate tor, pag		25. Was case referred to medical				26. Place of Dea	1□ Yes	2 No	1 ☐ Yes	2 1 No	_		
5	hysici his cer I direct	To Be	examiner? 1 Yes 2 No		R/Outpatien	3 DOA	her: 4 Nursing H	ome 5□Resi	dence 6 🗆		y)	_		
5	nding P th. r: After t e funera		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	iry at irk? ] Yes 2  □ No	28d. Describe	how injury oc	curred				
22	al or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Nu wn, State)	ımber or Rura	al Route Number,			
	ie Hospit n 24 hours ie Funera detely fille	Medical (	29a. Certifier 1 Feetifying Physic (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	/ledge, death on and/or inv	occurred at the trestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and date and pla	d manner as s ice, and due to	tated. o the cause(s)			
	To the Within To the Comp	Me	29b. Signature and title of certifier	Aurely,		29c. Licen:		9		gned (Month,				
•	6		30 Name and address of person who con	moleted cause of death (Item:	23a) (Tyne I	Print)	0617-8							
	5		LOKRAINE OF OR1-	ANUAN 5430	CAN	MBELL	- BLVD,.	STE 214,	BALT	NOLE	MD 21236	5		
	Sta Registr		31. Date filed (Month, Day, Year)  AUG 07 2009	32. Registrar's Signatu		2								
DH	MH 17 Rev 1/2	001			A									

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Evanture must be recilied at once.
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Division of Vital Records, P.O. Box 68760,	ospital or Attending Physician: The law requires that the death certificate be executed hours after death	ineral Director: After this certificate has been signed by the attending physician and yfilled in by the funeral director, page 2 should be detached for use as the burial-transit

Funera Director

	1 - For State Registrar  1. Decedent's Name (First, Middle						2.	Date of Deatl Month	Day	Year	3. Time of Death		
ian cal	Jeffrey L.	Wade					A	lügüst	6	2009	11:15a		
ner	4a. Facility Name (If not institution		n, or Location of	Death		_	ounty of Dea	th					
М	Carroll Hospita					inster	Hre I o	Date of Birth	_	rroll	thalan (State or Form		
	5. Social Security Number 040-36-1963 Usual Residence of Decedent	6. Sex 7. Age 1 7. Age 64	M 2□ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. A Date of Birth (Month, Day, Year) Months Days Hours Min. Dec 28 1944							Co	thplace (State or Fore ountry) CT		
	10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Lim		
ģ	MD Carro	)11	West	tminst	er						1 □Yes 2 🛣		
Funeral Director	10e. Street and Number 21 Washington A	Avenue Apt	. I		10f. Zip Co.			11	Og. Citize	en of What Co	puntry?		
Funera	11. Marital Status  1 □ Never Married 2 □ Marri	12. Was Decedent 6 Armed Forces? 1 XYes 2 \( \) If Yes, Give		. 13. Y		of Hispanic Origi Cuban, Mexican,	n? (Specit Puerto Ric	y Yes or No- can, etc.)		Black, Whit			
ed by	3 ☐ Widowed 4 🖾 Divorced  15. Decedent	Year or Dates:	196	0	I □ Yes 2 🔀					pecify: Will of Business			
Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  (Give kind of work done during most of working life. DO NOT use retired)  repair technician								NCR	CR			
Be Co	17. Father's Name (First, Middle, I	Last)					s Name (F	First, Middle, N	faiden S	ırname)			
To B	George Wade					Norma	Love	ejoy					
	19a. Informant's Name/Relationship (Type. Print)  Tera Harrington (daughter)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S. 5765 Palmer Dr., Castle Rock, Colorado												
	20a. Method of Disposition  1												
	21. Signature of Funeral Service L	Licensee		22	. Name and A	ddress of Facility					& Chapel		
	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that caused only one cause on each lin aa Due to (or as:	ista	tic	er the mode of		ardiac or r	espiratory arro	est,		Approximate Interval Between Onset and Death		
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
Physician/Medical	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)									23d. Date of delivery Month Day Year			
þ	Part II. Other significant condition	ons contributing to death bu	ut not resul	ting in the u	nderlying caus	e given in Part I.			oacco us		o the cause of death		
Completed									y ned? 2 No	prior to death?	utopsy findings availa completion of cause s 2 \( \sum \text{No} \)		
o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ent 2□F	B/Outnatie	nt 3 🗆 DOA	Othor:		Check only on 5 ☐ Reside		□Other (So	ecify)		
tion: To	27. Manner of ⊬eath 1 Natural 5 Pending	28a. Date of Inju (Month, Day	ry :	28b. Time o Injury		Injury at Work? 1 □ Yes 2 □ N	28	d. Describe ho			cony		
Certification:	2   Accident   Investigation   M   1   Yes 2   No     Accident   Suicide   A   Homicide   A									reet and Number or Rural Route Number, , State)			
Medical		g Physician: To the best Examiner: On the basis o and manner sta	f examinati										
M	29b. Signature and title of certifier  Abut C	2ù				cense number 4408		2	9d. Date	signed (Mon	2.009		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ajay Behari Mb Carroll Hospital Center 700 Memorial Av  31. Date filed (Month, Day Year)  32. Registrat's Signature											w interdentiacter		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5 2009 50 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. DENSONST 8. Date of Birth (Month, Day, 9/Birthplace (State or Foreign 7. Age (In yrs last birthday **Funeral** Days Min. Country) 1 M 2 □ F Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 NNo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be ဥ 19a. Informant's Name/Relationship (Type. Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State 200 22. Name and Address of Facility
JOSEPH L. RUS 21. Signatore of Funeral Service Licenses Rus 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner burial-transit physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as the attending IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably 2□ No 1 ☐ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 ☐ Yes certificate ! 2□No 2 No Division or Vital or Attending Physician: funeral director 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 npatient 2 ER/Outpatient 3 DOA ျှ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 Tyes 2 No 24 hours after death. ■ Funeral Director: A completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) 100 lary la . Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5, 2009 August 4:57 AM **Physician** Williams Wendell Eric /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital

5. Social Security Number 6. Sex 7. Age (In Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours 1**2** M 2□ F 217-62-136 Usual Residence of Decedent 13/1955 MARY AND Director 0d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Evaniment must be nutified at 1 Yes 2 □ No BALTIMORE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21218 Street 11 Wes Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? UNKNOWN 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FOOD SERVICE Elementary/Secondary (0-12) College (1-4or 5+) CATER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERALDINE BERNARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2 39 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. Sis , MARY (And ShEILA Ave., BALTIMORE MEAD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mem. PK. CEME 10 2009 BALTIMORE, MARY AND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The DERRICK C. JONES EH, P.A. Signature of Funeral Service Live see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dilated Cardio myopathy Physician /Medical Due to (or as a consequence of) years Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner y lears Hospital or Attending Physician: The law requires that the death certificate be executed hronic attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year Month 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has 2 🗆 No certificate 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Medical Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MD Union Memoria [OUNO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 07

DHMH 17 Rev 1/2001

Registrar

09-06	6093 ly Douglass	۱۸/۵	Please Typ	oe or Print i	n Black	Indelible	Ink. E	nsure	All Cop	ies Are Le	gible				
Nano	.——		I- For State			Certificate					Reg. No.	20	0 9 2 5 2 8		
Med	Physici ical Exami		Decedent's Name (First, Middle Randy Dou		Vetzel					Month August 5	, 2009	Year	0615 hrs		
1			4a. Facility Name (if not institution Frederick Memorial H	-	umber)		4b. City, 1 Fred		ocation of Dea	ath	1	County of Dear rederick	th		
	Funeral		5. Social Security Number	6. Sex	7. Age (In y	yrs. last birthday)	If Und	er 1 Year	If Under 24H	Hrs. 8. Date of B	irth (MM/I	DD/YYYY) 9. B C	irthplace (State or Foreign ountry)		
	Director		219-86-0334 Usual Residence of Decedent	1 X M 2 F		48	Yrs.	Dayo		Feb.	Feb. 7, 1961 Maryla				
	w any		10a. State 10b. County		10c.	City, Town or Lo	cation						10d. Inside City Limits 1 XYes 2 No		
	ryland a-f shov tonce.	to	Maryland Fre	ederick			10f. Zip		stown		10g. Citiz	en of What Co			
2	the Mar a or 28 tiffed a	Director		ibs Court					710 _		U.S.A				
202	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status	12. Was De	ecedent Ever Forces?		Was Decede If Yes, speci	ent of Hisp fy Cuban,	14. Race - Ame White, etc.	erican Indian, Black,					
	after dez N", or i ner mu	by Fu		orced If Yes, Give You	2 <u>X</u> paar	1	Yes 2			<u>-</u>		Specify:	White		
	hours a "natura Exami	ted b	15. Decedent's Education (Spe Elementary/Secondary (0-12)		ade complete				on (Give kind DO NOT use	of work done retired)	16b. K	find of Busines	s/Industry		
	5-0036 ited within 72 Hygiene. I other than	Completed	12		(, , , , ,		truck					nitatio	n co.		
	215-0 215-0 be filed w ntal Hygic rked othe ent, the h	Be Co	17. Father's Name (First, Middle Alfred Wetze					1		ame (First, Middle Mary Holt		Surname)			
	5, MD 21215-0036 and 2 should be filed within 72 hours after tealth and Mental Hygiera file. Them 27 is marked other than "matural"; traumatic event, the Medical Examinez.	To B	19a. Informant's Name/Relations	ship (Type, Print)					and Number	or Rural Route N	umber, Ci				
	and 2 s lealth ar tem 27 traums		Kimberly Gray/ 20a. Method of Disposition			20b. Place of Dis		me of cem		Adamstor Date	vn , N	Location - City	or Town, State		
	Pages 1 tent of Funt: If in a other		1 X Burial 2 Crematio 4 Donation 5 Other S		from State	crematory o			y 8	/10/2009	U	nionvil	le, MD		
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland bepartment of Health and Mental Hygiera. Important: If item 71's marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once		21 is ature of Funeral Service		1. 16	Per 2	2. Name and		1.	Martzler			me MD 21762		
	Physician	L.,	23a. Part I. Enter the disease, o failure. List only one cause	r complications that	cau	death. Do not ent	er the mode	of dying,	erty Ro	ac or respiratory	arrest, sho	ock, or heart	Approximate Interval Between Onset and		
· · ·	/Medical xaminer	9. 9	Immediate Cause (Final disease or condition resulting in death)										Death		
١,		L	Sequentially list conditions,	b											
		mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	C											
V	and and transit	Exa	events resulting in death) Last	Due to (or as	·				/						
	be exection and sician and surrial - t		XUNPENDED			27,perME	, g89.	5 9/2	/09 TT		- 100	1 8 (1-1)			
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwirthin 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Live	s, outcome o e birth	2	Fetal deat	n 3 [	Ectopic pre	egnancy	23	d. Date of deliving Month	Day Year		
	Box 6 e death ce the attend ed for use	ysici	1 Yes 2 No 9 Ur	-known	gnant at time (nown	e of death 5	Other (Sp	ecify)							
	P.O. Es that the gened by the detached	by Ph	Part II. Other significant cond	itions contributing	to death but	t not resulting in t	the underlying	ng cause g	iven in Part I.	23e. Di			to the cause of death?  Probably 4  Unknown		
	ds, F equires een sign ould be										as an	1 24b. Were	autopsy findings available to completion of cause of		
	ecor he law r ate has b	Completed								pe	topsy rformed? s 2 1	death	1?		
	of Vital Records, of Physician: The law requir wher this certificate has been someral director, page 2 should	Be C	25. Was case referred to medic examiner?	Hospital:	1				Other	ursing Home 5	Pasid	ence 6 O	ther:		
	n of Vi ding Physi I. After this funeral dir	₽	1 Yes 2 No 27. Manner of Death	28a. Da	Inpatient ite of Injury nth, Day, Year)	2 ✓ ER/Outpa 28b. Time		DOA 28c. Inju	ry at Work?			jury occurred	THE STATE OF THE S		
	ttendin death. ctor: A	Certification:		nding estigation					res 2 No		= /Ctroot	and Number of	Rural Route Number, City		
	Division tal or Attendir rs after death.  **A Director: △** led in by the fu	ertific		uld not be ermined   28e. P		- At home, farm,	street, facto	гу, опісе в	ullaing, etc.		n, State)	and Number of	Train Proble Hamber, Only		
	Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier	Physician: To the last	est of my kn	owledge, death o	occurred at t	he time, da	ate and place	, and due to the c	ause(s) a ate and p	ind manner as :	stated. o the cause(s)		
	To the within To the comp	Medical	29b. Signature and title of certif	and manne	er stated.			9c. Licens					(Month, Day, Year)		
4			WICC		MD			O.C.	M.E.		Au	gust 6, 200	9		
	(d)		30 Name and address of person Russell Alexander M	18828	ause of death		111 Penr	Street,	Baltimore	e, MD 21201					
	Pagi	tate				signatur									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Zavetto **Physician** 10:40 AM 2009 Green- Washire ton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimos 2 Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F WAShiwston, D. C 579-82-4960 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show injury or other traumatic event, the Predical Examinar must be notified at UPPER MARBORO 1 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or WHY 20770 3600 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. þ Il Hygiene. other than "natural", c 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. WORKEN Department of Health and Mental Hygis Important: If Item 27 Is marked other I any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HUS bew D UPPER MARBONO, W. D. ZO770 3600 ETON WAY 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GLINTON, 4 □ Donation 5 □ Other (Specify) FUNIERUL HOME HOWOLL 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 20794 1/255UA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician pulmonor Severe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ✓ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, hours after death. within 24 hours after death To the Funeral Director:

> State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier,

31. Date filed (Month, Day, Year)

ordon

07

and manner stated

30. Name and a diress of person who completed cause of death (Item 23a) (Type, Print)

M

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Swith Greena st Baltimore

29d. Date şigned (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** vebber 08 0910 -2009 HAROLD Reed 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Har 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, BALTIMORE TILCREST Hospice If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 □ F Yrs. 194-24-233 09-10-1931 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaminar must be notified at 1XYes 2 No **Funeral Director** BALTIMORE MY Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 964 21204 FAIRMOUNT Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No Yes, Give Year or Dates: Koref Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2XNo Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ELEMENTARY + TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Webber MILDRED Pottelger ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 of Health a (wife 964 webber FAIRMOUNT Ave. LOUSON mb 21204 June M. 3altimore, 20c. Location - Čity or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State pehocken (meter) 08 08-09 Myerstown 22. Name and Address of Picility 2134 William Sorth 4 Donation 5 Dother (Specify) 2134 Willen Spring 21. Signature of Funeral Service Lice ASHOOD F. H. P. A. BARGI, MD Z1222 Deadle, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mont **Physician** disease or condition resulting in death) /Medical Due to (or all a consequence of): Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of): 68760, for use as Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) the Ö 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Physician: The 1 ☐Yes 2 No Vital 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1X Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 No death. 7/6/2009 Unkrows 2 Accident 24 hours after deatl Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Dursing home 509 F Joppa Rd, Towish, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier .00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric Suite har 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Month Physician CHARLOTTE WEINER 730PM AUGUST 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN 8. Date of Birth 12/09/1931 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗶 F Months Days Hours ΜD 218-26-8212 77 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ntal Hygiene. ed other than "natural", or Items 23a or 28a-f shovevent, the Medical Eraminer must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE LUTHERVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21093 USA 11704 WOODLAND DRIVE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE Specify \$ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will.
Department of Health and Mental Hygiene Important: If Item 27 is marked other tha any Injury or other traumatic event, Inc. Once. RETAIL SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STOLER **JERRY** KATE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11704 WOODLAND DRIVE, LUTHERVILLE, MD ANDREA KLEIN / DAUGHTER 20b. Place of Disposition (Name of BE Temperary Employay or other place) Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/06/2009 BALTIMORE, MD ANSHE KURLAND Signature of Fune al Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 16 11(00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC NON SMALL CELLIUNG CANCE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infine rate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for selection reconstruction of Examine the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Brain Discase 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Anomia has performe Thrembocy to penia.
25. Was case referred to medical examiner? After this certificate funeral director, pagi 1 ☐ Yes 2 No the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other Specifies Hospice 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 M Natural 2 ☐ Accident 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier Medical f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who pleted cause of death (Item 23a) (Type, Print) 2835 Smith Are Svile 203 Baltimoro MO ton 31. Date filed (Month, Day, Year) 32/Registrar's Signatu State AUG Registrar

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N			Gilchrist Center  5. Social Security Number 6. Secu	/ 7 Δα	e (In vrs	last birthday)	Tow If Under		Mar If Under 2	yland	B. Date of Bir		Baltin		ce (State or Fo	oreian
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. 0	s 1 an f Hea f Hea other	-	Denise M. Zorn (120a. Method of Disposition		20b. P	lace of Dispo	sition (Name	e of	i	<u>– Cor</u>		20c. L	larylan .ocation - City	or Tow	21918 n, State	
3	Pages nento int: If		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		emetery, crei rkwood	•			8/08/	2009	Bal	.timore	, Ma	aryland	1
1:55 Am.	partition of interpretation 2 12 13 10 10 00 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madrial Exercitive must be retified at once.		21. Signature of Funeral Service Licens	saadn		2:	2. Name and	d Address	s of Facility	у <b>Е.</b> .	F. Las	sahı		ral	Home,	P.A.
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\$ 000 B	Physician: The law requires that the death certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome	2 Feta	I death 3[	Ectopic pro						23d. Date of Month		/ ay Yea	ιΓ
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>-	uires that I		Part II. Other significant conditions con	ntributing to death b	ut not resu	ulting in the u	nderlying ca	use given	n in Part I.		23e. Did	tobacco	use contribut	e to the	cause of deat	th?
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10,1	Sta Registr		31. Date filed (Month, Day, Year) AUG V ( 2009	32. Registra	ar's Signa	ture										

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# I per PHYS, G894, 87,7709, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) Cecilia A. Zarachowicz 3. Time of Death 2. Date of Death **Physician** 1:00/+M 0 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner izabeth Baltimo WYSING enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Pay, Year 917 9. Birthplace (State or Foreign 7. Age In yrs. last birthday) **Funeral** Days Maryland Months 1 □ M 2 🗗 F 215-14-5061 91 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1√Yes 2 No Director Baltimore City Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21224 613 South Lakewood Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify: Specify: White 2 3 ₩ Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. em 27 is marked other than other traumatic event, It and Own Home Home Maker 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Beida George Buczkowski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 301 Hillcrest Avenue Baltimore, Maryland Virginia Eidinger/Daughter Department of Health Important: If Item 27 any injury or other troops. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Rosary Cem 20c. Location - City or Town, State Date 20a. Method of Disposition 1€ Burial 2 Cremation 3 Removal from State 8-6-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilities aczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee Twhen Md.21222 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on seed line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician men 10 -e avs disease or condition resulting in death) /Medical Due to (or as a consequence of): PILVS **Examiner** phag Sequentially list conditions, if any, leading to final clatticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Civ Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760, Exami Due to (or as a consequence of): Physician/Medical ensim IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by rebra den C Vascu ar 2 No 3 Probably 4 Unknown 1 Tes this certificate has been s al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 41111 24a. Was an 1)101 autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 venue 32. Registrer State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

3. Time of Death

**Physician** /Medical Examiner

1 - For State Registrar

**Funeral** Director

28a-f show d 2 should be filed within 72 hours after death with the Marylai th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a4 shov traumatic event, the Medical Examination and the Medical Examination. permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is r any Injury or other traur

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician:

Examiner burial-transi and physician s the burial Physician/Medical attending for use a ned by the a s been signed the should be detailed ģ Completed page 2 s certificate has Be 2 this filled in by the funeral Director: After Certification: death. 24 hours after on Euneral Direc

To the within 2 State

Day 2009 July 25, 4:00 P M Gloria Mercedes Avalde-Perez 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 17808 Black Stallion Way Germantown Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov 3, 1963 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 🗓 F 45 218-86-3432 Suriname Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2√ No Director MD Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17808 Black Stallion Way 20874 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Colombian 14 Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jaime Ayalde Mercedes Llorente ပ 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gustavo Arnaldo Perez-Jaime 17808 Black Stallion Way Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 Removal from State Final Journey Crematory 07/26/09 Woodbine, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Ser Gring Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Breast Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 moni 1 □Yes 2 No months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【XUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature dittle of certifier 29d. Date signed (Month, Day, Year) 29c. License number July 25, 2009 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) Gary B. Wilks, M.D. 6430 Rockledge Drive #470 Bethesda, MD 20814

Registrar

31. Date filed (Month

parke

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. (... 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year Physician 19 3:28 P WILLIAM JULY 2009 Α. ARGYLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Sex ¥□M 2□F 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days MAY 25 1923 GUYANA 111-44-6405 86 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the "Modical Experience", ust be notified at 1 XYes 2 ☐ No Director PRINCE GEORGE'S HYATTSVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9048 CONTINENTAL PLACE 20785 GUYANA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after cariment of Health and Mental Hygiene.

ortant: If item 27 is marked other than "natural", or iter injury or other traumatic event, the Medical Exercites. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 🎾 No BLACK Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12TH POLICE OFFICER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM ARGYLE RACHAEL MYERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9048 CONTINENTAL PLACE HYATTSVILLE MARYLAND 20785 NOREEN ARGYLE/WIFE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State RIVERDALE CREMATORY: 7/24/2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departr
Imports
any Inje 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME of Euneral Service 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CARDIOVASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed HYPERTENSION the burial-tran and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical CARDIAC ARRHYTHMIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknow Completed 24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28d. Describe how injury occurred 27. Manner of Death 1 ANatural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 ☐Yes 2 ☐No M 24 hours after death. 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Fune

completely fi Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 21, 2009 D27566 JULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MOUNIR N. BOULOS M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 32. Registrar's Stinature 31. Date filed (Month, Day, Ya State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) JMenth 19<sup>ay</sup> 2009<sup>ear</sup> 2:33 P **Physician** ANOMFUEME CHIZOBAM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🗓 F 42 JUNE 9 NIGERIA Director 1967 None Usual Residence of Decedent 10d. Inside City Limit the Maryland 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ N PRINCE GEORGE'S BOWIE MD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 20716 NIGERIA 15906 PEACH WALKER DRIVE Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2√2 No Baltimore, Maryland 21215-0036 Specify Specify BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry traumatic event, It a Madical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE ACCOUNTANT 5+ 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be JOSEPHAT OFOEGBU VICTORIA OKORO ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 15906 PEACH WALKER DRIVE BOWIE, MARYLAND 20716 CHINYERE OKORO/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/14/2009 IMO, NIGERIA FAMILY PLOT 4 ☐ Donation 5 ☐ Other (Open 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Stanature of Funeral Service Lice 2. 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease Immediate Cause (Final disease or condition resulting in death) Physician LIVER METASTASES /Medical Due to (or as a consequence of): Examiner METASTATIC BREAST CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) page 2 should be detached 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ Unkno 24b. Were autopsy findings availa prior to completion of cause death? 24a. Was an autopsy performed? 2X No 27 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2- No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 1 ☐ Yes filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a, Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day, Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 07 JULY 21,

State

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SUGANTHI V. ALAGARSAMY M.D. 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MARYLAND 212 31. Date filed (Month, Day, Year)

ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

30. Name and

			State of Mary				lental Hygie	ne 009	25290		
			State Registrar	Cer	rtificate of L	Death		No.CUUD			
	Physicia	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death		
44	/Medic		Phyllis Arlene Alexander				July 31		5:24 P <sup>M</sup>		
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death		4c. County of Death			
			Ravenwood Lutheran Village  5. Social Security Number   6. Sex   7. Age (In	yrs. last birthday)	Hagerst		8. Date of Birth	Washington e of Birth 9. Birthplace (State or Foreign			
	Funeral Director		218-24-7521 1□ M 2\\ F 80	V	Months Days	Hours Min.	(Month, Day, Ye	ear) Cour	ntry)		
7			Usual Residence of Decedent				riai Cii 4,	1929 Mary	yland		
yach	how #		10a. State 10b. County 10c	c. City, Town or Lo	cation			1	0d. Inside City Limits		
Ma	a-f s	cto	MD Washington	Hagerstov	√n				1 Yes 2 □ No		
ŧ	or 28	Dire	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Cour	ntry?		
t i	23a	ra	11525 Englewood Road		2174			U.S.A.			
90	items	Funeral Director	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White,			
36	, or	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	I∐Yes 2∭ No	Specify:		Specify:	iite		
0	atura		15. Decedent's Education	16a. Deced	dent's Usual Occup	ation		b. Kind of Business/In			
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Maryland 21215-0036	yes I and 2 should it of Health and Mer if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type. Print) Thomas S. Alexander/Son		,		,	ity or Town, State, Zip	Code)		
0 6	Health Hem 27 i						lagerstown	c. Location - City or To			
altimore,	or of		1 M Burial 2 Li Cremation 3 Li Removal from State 1		sition (Name of natory or other plac			·			
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Bal	Department of Important: If Ite any injury or of once.		21. Signature of Funeral Service Licensee					Funeral Cherstown, M	-		
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			shock, or heart failure. List only one cause on each line.			12	or roop natory arroot	9	Interval Between Onset and Death		
	hysician /Medical		disease or condition		MIAL	Blue			Iranilu		
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<b>o</b> ,	an ar rial-tr	EX	resulting in death) Last Due to (or as a co	nsequence of):							
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P.O. Box	by the a	Physician/Me	1 ☐ Yes 2 ☐No 4 ☐ Pregnant at tim 9 ☐ Unknown 9 ☐ Unknown	e of death 5L	Other (specify)						
<u>.</u> ‡	ad by Jetac		Part II. Other significant conditions contributing to death but no	t resulting in the ur	nderfying cause give	en in Part I.	23e. Did tobac	cco use contribute to t	he cause of death?		
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	s peen s	etec					24a. Was an	24h Were auto	onsy findings available		
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			25. Was case referred to medical			OC Plans of Dan	1 ☐ Yes 2 ☑ th (Check only one)	No 1 ☐ Yes	2 □No		
	s certific lirector,	o Be	examiner?	2 ER/Outpatier	ot 3 🗆 DOA Oth			e 6 ☐ Other (Speci	f <sub>v</sub> )		
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VIS	after death.  I Director: A id in by the fu	iţi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,		
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Division of Vita	24 hours e Funeral	edical	29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, deatl	h occurred at the til	me, date and place	, and due to the cau rred at the time, date	se(s) and manner as and place, and due t	stated. o the cause(s)		
the	within 24 ho To the Fune completely f	Medi	one) and manner stated.		200 Lianno	a number	204	Data signed (Month	Day Yazr)		
٥	or Sor	Σ	29b. Signature and title of certifier		29c. Licens		290	. Date signed (Month,			
			Manger gray	(I) CC 1 ==		, w J			<del>,</del>		
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print) - Heraeta	u MD	21740				
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's 31. Date filed (Month, Day, Year) 32. Registrar's 32. Regist	Signature	1-10-		- [ -				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1y 23, Lisa Kirby 200Š Blake 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 140 Austyn Court St. Leonard Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Hours Year) Days Min. 1 □ M 2 🖾 F 219-94-7680 Director Nov 23. 1965 Landover, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f sho Director MD Calvert St. Leonard 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 140 Austyn Court 20685 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: White ş Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Automobile Dealer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evone. Thomas Kirby Treva Read ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Blake (husband) 140 Austyn Court St. Leonard, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State July 27 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Highlands 2009 Port Republic, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. &off 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast 4ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Exami Due to (or as a consequence of): Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 💢 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 TAccident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

O. Box 68760 the death certificate be the attending Por signed by the a σ. The law requires that Division of Vital Records, peen has certificate or Attending Physician: this funeral After in 24 hours after death.

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12 should be filed within 7 h and Mental Hygiene. 7 **Is marked other than "** 

Saltimore, Maryland 21215-0036

Hospital completely To the within 2 To the I den 5

MD D005906 23,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arati Patel, MD 110 Hospital Road Ste 212 Prince Frederick, MD 20678 31. Date filed (Month, Day, Year)

1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Registra Signature JUL 24 2009 Cleneura

and manner stated.

Darken

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month **Physician** Opa1 Bow lui 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PL PTA If Under CHARLE MISTA DICA Hrs. 8. Date of Birth Min. (Month, Day, Year) November 3,1917 9. Birthplace (State or Foreign Country) TN 5. Social Security Number Age (In vrs. last birthday) Months Days Hours 312-01-4778 1 □ M 2 😾 F 91 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No MD Director Charles Bryantown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7022 Leonardtown Road 20617 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 24 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No White Specify: 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Caregiver Elderly Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eldon Sewe11 Leann Goad ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arkley Smith, Jr./Son 7000 Leonardtown Road, Bryantown, MD 20617 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Mt. Helen Cemetery 7/28/2009 Allardt, TN 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee M00945 22 AREHARTEECHOUS FUNERAL HOME, P.A. QL 211 St. Mary's Ave. La Plata, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Immediate Cause (Final disease or condition resulting in death) nacostive Due to (or as a con equence of): Sequentially list conditions, if any, reading to find ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 1 Yes 2 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Division of Vital Records, P.O. Box 68760, physician the attending p ned by the a sate has been signed page 2 should be det certificate filled in by the funeral director, Medical Certification: To this 24 hours after death. Funeral Director: After

**Funeral** 

Director

show

ortant: if item 27 is marked other than "natural", or items 23a or 28a-1 shov Injury or other traumatic event, the Medical Examinar must be nodified at

Hygiene.

Health and Mental em 27 is marked o

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

BOW

5 ☐ Pending investigation 6 ☐ Could not be 3 Suicide determined 4 Homicide

29a. Certifier

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

101 Waldorf, MD 20602

29b. Signature and Mile

00061652

29d. Date signed (Month, Day, Year) 2009

Name and address of person who completed cause of death (Item 23a) (Type, Print) iite

31. Date filed (Month, Day, Year)
JUL 2 4 2009 32. Registrar's Signature

and manner stated.

State Registrar

within 2

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			Please	Type or Prin						-		_	
	•	For State Registrar		State of Ma	arylan		epartme C <i>ertifica</i>			Mental Hy	giene Reg. No.	711114	25293
Physicia		1. Decedent's Name		C.		В	aldrid	₂e		2. Date of De Month		of Zoog	3. Time of Death
/Medic Examina Funeral		4a. Facility Name (I	Country Jumber 6.	ve street and number) Ridge Driv Sex 7. Ag	e e (In yrs. I	ast birth	4b. Cit	y, Town, o Upp er 1 Year	r Location of Dea er Marlt If Under 24 Hr Hours Min	DOTO S. 8. Date of Bi (Month, D	4c.	9. Birthp	e George's  Clace (State or Foreign  Chry)  Ch Dakota
Director		338-12-5 Usual Residence of 10a. State	0000	X   90	10c. City		or Location		<u> </u>	Oct.	12,		Od. Inside City Limits
the Maryli 28a-f sho	Director	Maryland 10e. Street and Nu	l	George's	Upp	er .	Mar1bo	r O Lip Code			10g. Cit	tizen of What Cour	1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then Z7 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exp. nit or must be notified at once.	Funeral D	11. Marital Status	Country R	idge Drive		S.	1	20772 edent of F edify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)		U.S.A. 14. Race - Americ Black, White,	
2 hours aft natural", or	þ	3 □XWidowed	4 Divorced	1   Yes 2   Yes, Give X Year or Dates:	40	16a. I	Decedent's Us	2 X No	Specify:	orkina	16b. K	Specify: What	
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and 2 sho ealth and m 27 Is m			Hollabau	<sup>(Type. Print)</sup> gh (Daught	_	1	0503 C	ountr	y Ridge	Drive U	pper	or Town, State, Zij  Marlbord ocation - City or To	o, MD 20772
Pages 1 tment of F tant: If Ite	20a. Method of Disposition  1								Cem.	y <sup>□</sup> 2 <sup>t</sup> 7, 2009	Che	ltenham,	Maryland
permit Depar Impor any In		21. Signature of F	Hyde	Mos	_ \		6633	01d	Alexand	ria Ferr	y Ro	Home, Inc	on, MD20735
Physician /Medical Examiner		23a. Path. Enter of shock, or hea Immediate Cause disease or condition resulting in death)		Approximate Interval Between Onset and Death									
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e law requires that has been signed b	ρ	Part II. Other signi	. 1	contributing to death b	ut not res	ulting in	the underlying	g cause gi	ven in Part I.		tobacco Yes 2		the cause of death?
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ysiciar s certif	To Be	25. Was case refe examiner? 1 ☐ Yes 2 ☐		Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Out	patient 3	DOA Ot		eath <i>(Check only</i> Home 5 ☐ Re		Daughter.	s residence
Attending Physician: r death. ector: After this certific. by the funeral director,	ation: T	27. Manner of Dea 1 Matural 2 Accident	tth 5 ☐ Pending investigati	28a. Date of Inju (Month, Da	ırv	28b. T	·	28c. Inju		28d. Describe			
: P # # :	Certification:	3 Suicide 4 Homicide	6 Could not determine	d 28e. Place of in building, el						City or To	own, Stat	<u> </u>	
To the Hospital vithin 24 hours a forthe Funeral I completely filled	edical	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											stated. to the cause(s)
To the within To the compi	Me	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yea  145.931  29d. Date signed (Month, Day, Yea										, Day, Year) 2009	
<b>B</b> 3		30. Name and add	Press of person wh	so completed cause of a	200	0 0	Type, Print)	Are	me Bo	athmone	M	D 21200	?
Sta Registr		31. Date filed (Moi	nth, Day Lear 2 4	2009 32. Regist	rar's Signa	ature	home	1.1	- 1				

Joseph Brewer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **UNK UNK** 1- For State Certificate of Death Rea. No. Registrar 3. Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ July 17, 2009 2315 hrs Medical Examiner JOSEPH BREWER 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Country Months Hours APRIL 7 1973 WASHINGTON, DC Director 579-90-4118 36 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State X Yes 2 No DISTRICT HEIGHTS MD PRINCE GEORGE'S 28a-f shov or items 23a or 28a-f sho must be notified at once, 10g. Citizen of What Country? 10f. Zip Code Direct 10e. Street and Number USA 6729 DARKWOOD COURT 20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Pages 1 and 2 should be filed within 72 hours after death with Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: 4 X Divorced If Yes, Give Year Yes 2 X No specify: BLACK 3 Widowed Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the Madical other than 21215-0036 NONE 12TH DISABLED and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) is marked it: If item 27 is marked other traumatic event, æ TOMMY BREWER CONCHITA GRAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19a. Informant's Name/Relationship (Type, Print) Itimore, MD 6729 DARKWOOD COURT DISTRICT HEIGHTS, MARYLAND ALTHEA BREWER/SISTER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a, Method of Disposition 2 X Cremation 3 Removal from State Burial Important: RIVERDALE CREMATORY 7/28/2009 RIVERDALE, MARYLAND Donation 5 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funer Service icensee 7474 LANDOVER ROAD LANDOVER, MARYLAND Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death 'Medical a. Gunshot Wound of the Chest Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed ian/Medical AMENDED attending physician or use as the burial -UNPENDED Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 hysici Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? 立 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 ✔ No 3 Probably 4 Unknown ò Division of Vital Records. P. Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? certificate has 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Residence 6 Other Inpatient 2 CER/Outpatient 3 Nursing Home 5 this 1 Yes 28d. Describe how injury occurred After 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject shot Jul 17, 2009 2201 hrs Natural Yes 2 ✔ No Pending hours after death Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 1505 Pine Grove Road, Capitol Heights, MD Suicide (Specify) Front yard 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number July 18, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) OCME Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD 31. Date filed (Menth Registrar's Sign ture

DHMH 17 Rev 1/2001

State Registrar

### State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 19 JULY 2009 **Physician** BAYLOR TESSE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S CAPITOL HEIGHTS 424 69th PLACE 8. Date of Birth (Month, Day, Year MARCH 12, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Min. Year) Months Hours 1 € M 2 □ F Yrs 78 1931 Director 579-38-5154 Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I've Madical Experient erust be rutfilled at Director MD PRINCE GEORGE'S CAPITOL HEIGHTS 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 424 69th PLACE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖔 No 11. Marital Status 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE CONSTRUCTION 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAWSON PINK BAYLOR ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun 424 69th PLACE CAPITOL HEIGHTS, MARYLAND BEATRICE BAYLOR/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 7/29/2009 CLINTON, MARYLAND J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Signature of Funeral Service 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of): physician Box 68760. Physician/Medical the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 I Unknown 1 Tes

signed by the detach Records, **Division of Vital** Hospital or Attending Pl 24 hours after death. Funeral Director: After the To the Hospital of within 24 hours at To the Funeral D

Completed

Be (

Certification: To

Medical

			autopsy performed? 1 □ Yes 2X□ No	prior to completion of cause of death? 1 □Yes 2XINo										
25. Was case referre	d to medical		26. Place of Death (Check only one)											
examiner? 1 □ Yes 2 □XN	lo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	ome 5 XResidence 6	ne 5 XResidence 6 Other (Specify)									
27. Manner of Death 1 X Natural 2 ☐ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	'	Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	occurred							
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, fac y)	28f. Location (Street and City or Town, State)	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a Certifier 1	Certifying Ph	vsician: To the best of my kno	wledge, death occur	red at th	he time, date and place	e, and due to the cause(s)	and manner as stated.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

SOUTH CAROLINA

10d. Inside City Limits

Yes 2 No

9. Birthplace (State or Foreign

BLACK

20743

20785

Month

Day

24b. Were autopsy findings available

Approximate Interval Between Onset and Death

3:50AM

nd title of certifie 29b. Signatu

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

24a. Was an

29d. Date signed (Month, Day, Year) 29c. License number -09 D32261

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

and manner stated.

RICHARD FELDMAN 9500 ANNAPOLIS ROAD #A LANHAM, MARYLAND M.D

State Registrar

(Check only

32. Registrar' Signatu

09-05641 Clarence W. Baylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2009 25296

		- For State egistrar				Certific	ate of i	Death					Reg. No	о.		
Physicia Iedical Examin	n/ 1	. Decedent's Name (		w.	ВА	YLOR						Date of De Month July 18, 2	Day 2009			3. Time of Death 2310 hrs
	2	a. Facility Name (if n	not institution, g		ımber)		46	City, Tov	vn, or Lo	ocation of	Death			Prince G		5
Funeral Director	ţ	5. Social Security Nur		Sex		yrs. last birt		If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of E			9. Birth Cour WASI	place (State or Foreign htry) HINGTON, DC
Director	Ļ	577-74-05	13	XM 2 F	5.5		Yrs.					TIAI	<i>ـ.</i> /		W21D1	111(0101,920
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nd show:	١	MD	PRINCE	GEORGE'	S	CAP	ITOL	HEIG	HTS							1 X Yes 2 No
eath with the Maryland items 23a or 28a-f show any ust be notified at once.	Director	10e. Street and Numb						10f. Zip C	ode 2074	. 2			10g. C USA	Citizen of Wh	at Count	ry?
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ath wit items	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex								Mexican, I	Puerto R	ican, etc.)	10-	White		
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2 hours after "natural",  Examiner	ğ P	15. Decedent's Edu				during most of working life. DO NOT use retired)							. Kind of Bu	siness/In	dustry	
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D 27 should and Me 7 is mg	유	19a. Informant's Nam												N,DC		
b, MD and 2 sho lealth and tem 27 is traumati	ŀ	BRON BAY 20a. Method of Dispo		N		20b, Place	of Disposi	tion (Name	of cem	etery,	11. V	Date	20	c. Location -	City or	Fown, State
Baltimore, MD 212 per it. Pages I and 2 should be Deep timent of Health and Ment Important: If item 27 is mark injury or other traumatic ever	-	1 X Burial 2 Cremation 3 Removal from State Crematory or other place) RESURRECTION CEMETERY 7/2									/29/2009 CLINTON, MARYLAND				ARYLAND	
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P.O. Box 687 s that the death certific pred by the attending t	Physicia	past 12 months?			gnant at tim	e of death		ner (Spec	ify)				Ц			
the dez	Phys	Part II. Other signif		90118	nown to death b	ut not resulti	ng in the u	inderlying	cause g	iven in Pa	rt I.	23e. Di	d toba	cco use cont	ribute to	the cause of death?
cords, P.O. law requires that has been signed be see should be detail	ρ	•						_				1	Yes	2 <b>✓</b> No 3	Prob	pably 4 Unknown
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eco he law ate has	dmo												erforme es 2		death? I ✔ Ye	es 2 No
al R ian: T sertific ctor, p	O	25. Was case referre	ed to medical							of Death	<del></del>					
F Vit	To B	1 <b>✓</b> Yes 2	2 <b>N</b> o	Hospital: 1	· · · · · · · · · · · · · · · · · · ·	2 V ER/	Outpatient  Time of I		<i>"</i>	Other <sub>4</sub>		g Home 5		sidence 6	Othe red	r:
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach		<ul><li>27. Manner of Death</li><li>1 Natural</li></ul>	n 5 Pendir	Jul 18	te of Injury hth Day Year , 2009	) 22	16 hrs	iljui y		res 2 ✓	. 19	Subject s				
risio r Atter ter deat irector n by th	ficat	2 Accident 3 Suicide	Investi 6 Could	gation 28e Pi	ace of Injur	y - At home,	farm, stre	et, factory,	office b	uilding, et		or Tow	n Stat	۵)		ural Route Number, City
Subject stabbed  1 Natural 2 Accident 3 Suicide 4 Minimal 4 Minimal 2009  1 Natural 2 No Subject stabbed 5 No Subj																
Division of Vital Records, P.O. Box 68760, To the Hospital or Atending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a. Certifier (Check only one)	Certifying Phy Medical Exam	rsician: To the biner:On the bas	est of my k	nowledge, o	leath occui	rred at the tion, in my	time, da opinion	ate and pla , death oc	ace, and curred a	due to the o	ause(s ate an	s) and manne d place, and	er as stat due to th	ed. ne cause(s)
To To To the comp	Medical	29b. Signature and		and manne	r stated.					e number						onth, Day, Year)
	_	1110.	K	ull)	M	•			O.C.I	M.E.				July 19, 2	009	
2		30. Name and addre	recas	100,11	auso of dea	th (Item 23a	1)									
OCME		Melissa Bras	ssell, MD	Assistant N		xaminer		Penn Str	eet, B	Baltimor	e, MD	21201			_	

			For	State o	of Marylan		artment of F		Mental Hy	giene	000	05207
			1 - State Registrar	1 - 1)		Cei	rtificate of	Death	2. Date of Dea	Reg. No.	009	3, Time of Death
	Physici	an	1. Decedent's Name (First, Middle Candace Clair						Month	Day 22	Year 2009	2:55 A <sup>M</sup>
1	/Medic		4a. Facility Name (If not institution		ımber)		4b. City. Town, or	Location of Death	July		anty of Death	
3	Examin	er	National Inst	_			Betheso			Мо	ntgome	ery
I	Funeral Director		5. Social Security Number 169–42–4889	6. Sex 1 ☐ M 21 F	7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Aug. 12	1 <sup>th</sup> 1 <sup>7</sup> 949	9. Birth Cou	nplace (State or Foreign Intry) Onio
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 Cit	v. Town or La	position					10d. Inside City Limits
	laryla f shov	ō		None	100.01		ington, D	) C				1 ⊈Yes 2 □ No
	the N 28a-i	Director	10e. Street and Number	None		wasii	10f. Zip Code			10g. Citizen	of What Cou	untry?
	3a or	Ē	2714 35th Pla	ce, N.W.			20	007		U.	S.A.	
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene.  marked other than "natural", or items 23a or 28a-f show imatic event, it all first in the fi	y Funeral	11. Marital Status 1 □ Never Married 2 🛣 Marr	Armed Formed Toler   If Yes, G	23⊈No ive		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ĀNo	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	s or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White		
21215-0036	hours tural"	ed by	3 ☐ Widowed 4 ☐ Divorced  15. Deceden		Dates:	16a Dece	dent's Usual Occup	pation			of Business/II	
75	filed within 72 Hygiene. other than "na oth, the Medic	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)		(Give	kind of work done DO NOT use retired	during most of wor d)	king	Development		
212	d with giene er tha	Com	Elementary/Secondary (0-12)	College (	1-401 5+)	Con	sultant	destro		Consu	1tancy	7
p	be file Ital Hy d oth event	Be	17. Father's Name (First, Middle,	·				18. Mother's Nan			name)	
<u>\}</u>	should be f and Mental I s marked of tumatic eve	은	Arthur Anderso		Naeyaer		Ct-t- 7	"- Cada				
Maryland			19a. Informant's Name/Relations Richard P. Par		d	1	ng Address (Street 35th Pla					
	s 1 and 2 of Health item 27 i		20a. Method of Disposition				osition (Name of matory or other place		Date	-	on - City or T	
altimore,	Pages nent of int: If it		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		Cemetery			Washi	ngton,	D.C.
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service	Licensee	M0131	5 22	2. Name and Addre	ss of Facility De				n, D.C.20007
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat					-		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	4	Mastic.	1 250-	Cellin	in ahrm	2		1	Onset and Death
lud.	/Medical		resulting in death)	a. Due t	(or as a conseq	uence of		mprican	-			9-01-0
	Examiner	يا	Sequentially list conditions,	b. Chrc	nic G	rafts	IS HOSE	discas	C			1 year
λ_	ted nsit	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(טו מז מ טטווזפען		1					8 1 -
<u>_</u>	execuna and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):	pacter	EMIA				o days
68760,	icate be executed physician and s the burial-transit	dical		d. Ace	nitobe	oter	bacte	emia				Imonth
Box	at the death certific by the attending prached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d.	. Date of deli Month	very Day Year					
J.	s that I		Part II. Other significant condition	ns contributing to c	leath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
g	quire; en sig uld be	ed by	Anemia						1 🗆 '	Yes 2 N	lo 3□ Pre	obably 4 Unknown
Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed							24a. Was auto perfo 1 □ Yes		4b. Were autoprior to death?	topsy findings available completion of cause of 2 No
Ĭ K	ician certifi ector,	Be	25. Was case referred to medical examiner?	Heavitals >			oth Oth	or:	ath (Check only o			
ō	Phys r this eral dii	<u>ا:</u> 1	1 Yes 2. Ho 27. Manner of Death	28a. Date	of Injury	ER/Outpatie	III 3 LI DOA	4 LI Nursing F	lome 5 ☐ Resi 28d. Describe			cify)
o	nding ath. :: Afte e fune	atior	1 → atural 5 ☐ Pendin 2 ☐ Accident investi	9	nth, Day, Year)	Injury		kí?  Yes 2 □No				
Division of	al or Atte s after des Il Director ed in by th	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined   286, Place	e of Injury - At ho ling, etc. (Specif	ome, farm, sti	reet, factory, office		28f. Location (. City or To		umber or Ru	ral Route Number,
	e Hospita 24 hours e Funera letely fille	Medical (		ng Physician: To th Examiner: On the and mar								
	To th within To th comp	Me	29b. Signature and title of certifie	10		200	29c. Licens		2.	29d. Date si	igned (Month	n, Day, Year)
	10		1V266/	alchar	i MI	Phl	) 4	30/08 6	5284	07/	22/0	9-0400H
			30. Name and address of person	·	ise of death (Iten			-				2000
	-01-	to	Nehal Lakhan: 31. Date filed (Month, Day, Year)	<b>D</b>	Registrar's Signa	ture -	10 Center	Drive, Be	ethesda,	Mary]	and 20	0892
	Sta Registr		JUL 24 2	009 En	Registrar's Sign	par	Ked.					
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			For State	State of Marylar	-				711114	25298
			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	rtificate of L	Jeath	Reg. 2. Date of Death	No.C U U J	3. Time of Death
	Physicia /Medic			ycomb aka	Sophia	Bojinoff			Day 2009 Year	7:20pM
	Examin		4a. Facility Name (If not institution, give stre			-	Location of Death		4c. County of Death	
		100	3124 Gracefield Ro  5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year	er Spring	8 Date of Birth	9 Birth	gomery place (State or Foreign
	Funeral Director			2 <b>X</b> F	91 <sub>Yrs.</sub>	Months Days	Hours Min.	(Month, Day, Ye Nov. 24,	ar) Cou	Indiana
7	W all		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
4	f sho	tor	,	gomery		ver Spri	ng			1 □Yes 24©XNo
4	or 28a	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?
4	23a (	ral	3124 Gracefield Ro				20904	US		
70	Items	Funeral	11. Marital Status 12. Married 12. Married 12.	Was Decedent Ever in L Armed Forces? 1 Pyes 2 No	J.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
d Z I Z I 3-0036	Eng.	by	3 Widowed 4 Divorced	1/ V Oi	I era	I∐Yes 2MENo	Specify:		Specify: Wh	ite
ָרָה בְּיִר	natur ofical	etec	15. Decedent's Educat (Specify only highest grade c	on om <i>pleted)</i>	(Give	dent's Usual Occup kind of work done	during most of worki		. Kind of Business/Ir	ndustry
71.	than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo NOT use retired stered No	,		Health	Care
מל ל	al Hyg other vent, I	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, Maio	den Surname)	
ylar Valar	Menta Menta arked	2	Stoian Bojinoff				Toda Unk	nown		
Mar	penium rages i and a Should be med within 72 mous arier beauf with the Mallyran Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Donald E. Claycomb/		19b. Mailir	g Address (Street a 124 Grac	and Number or Run efield Rd	al Route Number, Ci ., #107,	ity or Town, State, Zi Silver Sp	p Code) ring, MD 2090
ָב בּ	Item other		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other plac		Oate 1y 24,	. Location - City or T	own, State
altillior	ment tant: If		1X Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Pa		Memorial		009 Ro	ckville,M	aryland
סמו	Depart Import any In		21. Signature of Funeral Service Licenses	nlo	22 F	Name and Address rancis J 00 Unive	ss of Facility • Collins rsity Blv	Funeral	Home Inc. lver Spri	ng, MD 20901
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one		ath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Congestiv		t Failure				Chisci and Scalif
	xaminer			Due to (or as a consecutive Valvular		)i aonao				
T	± .	ner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	Date to (or as a consec		Disease				
1	and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to form a series						
S, S	physician and the burial-transit	dical E		Due to (or as a consec	quence on.					
Too Hit	ig phy as the	ledic	0							
לאם קבור מילים היים	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	tal death 3 □	Ectopic pregnanc	y		23d. Date of deliv	very Day Year
of Attainting Physician. The law requires that the death certificate he executed	the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	fdeath 5	Other (specify)			I I I I I I I I I I I I I I I I I I I	Suy .ou.
that	signed by the a	by Ph	Part II. Other significant conditions contri	outing to death but not re-	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tobao	co use contribute to	the cause of death?
Soliine	s been sig should be	ed p	Chronic Renal Insuf	ficiency, O	steopoi	cosis,		1 🗆 Yes	2 <b>X</b> No 3☐ Pro	bably 4 🗌 Unknown
i wet	has be	Completed	Breast Cancer					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 - 7 -	ficate r. page							performed 1 □Yes 2 🔀		2 □No
VII.	s certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	pital: 1 ☐ Inpatient 2 ☐	☐ FR/Outnatier	ot 3 🗆 DOA Othe	Dr:	n (Check only one)	e 6 □Other (Spec	(6.1)
5 6	After this certificate hi funeral director, page	on:To		28a. Date of Injury (Month, Day, Year)	28b. Time of			28d. Describe how i		y/
O ibild	tor A the fu	catio	2 Accident investigation	20. 81		M 1 □	Yes 2□No	001 111 (0)		15
	a er c i Direc d n by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. <i>(Spec</i>	nome, tarm, stre cify)	eet, factory, office		City or Town, S	t and Number or Rui tate) ► ∞	ai Houte Number,
The Hosnital	within 24 hours are redeath.  To the Funeral Director A completely filled in by the fu	edical C		ian: To the best of my kn						
To the F	ithin 2 b the F omplet	Medi	one)  29b. Signature and title of certifier	and manner stated.		29c. License	e number	29d.	Date signed (Month	, Day, Year)
ř	10+1	,		hell al	<u> </u>					
	1 -		30. Name and address of person who comp	leted cause of death (Ite	em 23a) (Type,	Print)	/* /	3.// D	1 01	y Spring
	Sta	to.	31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature .	3110	Gracet	rela sh	MD 2 na	y opning
	Registr		JUL 24 2009	olleted cause of death (Ite A Lex (on 33 Registrar's Sign	1. pa	Ked				~ /

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 23a per phys. G894 8/II/09 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 0500 2009 Alfred Veon Clifton July 21 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Carroll Westminster Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Oct 23 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1⊠ M 2□ F 83 W.VA 212-50-2849 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show if than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at 1 ☐ Yes 2 ☑ No Director Westminster Carroll MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21158 1161 Old Taneytown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XXIo Specify. Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 3 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Letha Hannah Hamerick Emory Earl Clifton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a important: If item 27 is any Injury or other trau 1161 Old Taneytown Road Westminster, MD 21158 Lula Mae Knisley/sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Pk | 7/24/2009 Sykesville, MD Privite of the rate of the P.A. 21. Signature of Juneral Service Censes 21157 412 Washington Road Westminster, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. immediate Cause (Final disease or condition resulting in death) **Physician** Society /Medical Due to (or as a consequence of): Unknown Examiner Hypotension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 - Ectopic pregnancy Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 🗖 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? to, Be 26. Place of Death (Check only one) funeral dire Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

requires that the death certificate be executed

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Vital Records,

Division of

with

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

THOMAS VL.

29b. Signature and title of certifier

32. Registrar's Signature

MA

K. Gales ig m

COSTLVIN TIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

park

29c. License number

23/660

STOWER

Avenue

29d. Date signed (Month, Day, Year)

Wesminster MAKE

22/2009

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 **Physician** 9:30 PMM July 16, Paul C Craig /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Sykesville Brinton Woods 8. Date of Birth (Month, Day, Year) 7/15/1933 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. XXM 2□F MD 219-30-3784 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 Director Randallstown MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10116 Liberty Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? FIZYes 2□No If Yes, Give 1961 Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes ŽŽNo Specify Specify Completed by **¾** Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 12 should be filed within; hand Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 9th College (1-4or 5+) K-Mart Maintenace Man 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Mary K Callery Clarence Craig ۵ 19a. Informant's Name/Relationship (Type. Print) Naomi Craig (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10116 Liberty Rd Randallstown, MD 21133 Department of Health a Important: If item 27 is any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Pages 7/21/2009 Woodlawn Cem. Sykesville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fund Burrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 eda. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line., Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) ASCULAR 4/ Physician /Medical Due to (or as a consequence of) Examiner CEREBRO VIBLUUR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2/2/100 26. Place of Death (Check only one)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

Be Completed 2 Certification: after death in by

25. Was case referred to medical examiner?

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

1 ☐ Yes 2 ☐ No 27. Manner of Death 5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🔲 Inpatient

2 ER/Outpatient 28b. Time of

3□ DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

1000 LIBORTY RD

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URNIS 4120

Hospital:

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

filled 24 hours a

within 24 hou

To the Fune

completely fi

Medical

09-05704	
Steven Cabezas	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			e of Death	Reg. N	lo. 200	9 2531
Physicia	n/	Decedent's Name (First, Middle,Last)		Date of Death     Month Da		Time of Death 2024 hrs
ledical Examin ∕		Steven Cabezas  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	July 20, 2009	4c. County of Death	20241115
		1675 Marshall Hall Road	Bryans Road		Charles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		s. 8. Date of Birth (M	M/DD/YYYY) 9. Birth Foreign	place (State or
Director		217-64-7785   1X <sub>M</sub> 2 <sub>F</sub> 54	Yrs. Months Days Hours Mir	February	3,1955 Wes	shington DC
пу	F	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			0d. Inside City Limits
Maryland 28a-f show any d at once		MD Charles Bryans	Road			1 Yes 2 X No
arylan 8a-f sl	Director	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Count	ry?
ith the Maryland 23a or 28a-f sho notified at once		1675 Marshall Hall Road	20616		USA	
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "matural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>		14. Race - America White, etc.	an Indian, Black,
ter dea		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Wh	ite
ours af	a p	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation (Give kind of		b. Kind of Business/In	
6 n 72 hc an "ns ical Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)		sured)		
5-0036 led within 72 Hygiene. I other than *	E O	12 F	Ingineer 18.Mother's Nam	ne (First, Middle, Maio	Construct den Surname)	1011
21215-0036 uld be filed within 7; Mental Hygiene. marked other than c event, the Medical	$\sim$ 1	George Christobal Cabezas	Cecilia			
5 9 9 g 5	ျှ	1	Mailing Address (Street and Number or			
ore, MD ss 1 and 2 shu of Health and If item 27 is	-		B10 Brickfront Plac		ta, MD 206  Oc. Location - City or T	
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic		1 X Burial 2 Cremation 3 Removal from State Cremator	y or other place)   Heart Cemetery 7/	27/2009 1	Ia Dlata M	arv1 and
Baltimore permit. Pages 1 Department of 1 Important: If injury or other	ł	4 Donation 5 Other Specify: Sacret 21. Signature of €oqeral Service Licensee M00945	22. Name and Address of Facility AREHART—ECHOLS F		WE D. A	
E Per De Constitution		23a. Part I. Enter the disease, or complications that caused the death. Do not	211 St Mary's A	ve. La Pla	ata MD 20	
Physician /Medical		failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
caminer	İ	Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):				Death
		Sequentially list conditions, b.				
	Examiner	if any, leading to immediate  Due to (or as a consequence of):  Cause. Enter Underlying Cause			- 0	H
ı ı	xam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
iO,  e be executed ysician and burial - transit		d. UNPENDED AMENDED				
50, te be ex nysician	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
6876 ertificat ding phy		23b. Was decedent pregnant in the past 12 months?	Month D	ay Year		
Box 68760, death certificate b he attending physical for use as the but	ysician/	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)			
that the do	/ Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		cco use contribute to t	
S, P.O	od be			-	2 ✓ No 3 Prob	
cords, law requir has been s	Completed			24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
il Rec in: The la rtificate h	اق اق			1 <b>✓</b> Yes 2		s 2 No
ital Redician: The scertificate rrector, page	Be	25. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/Ou	26.Place of Death (Checkpatient 3 DOA Other Number 1		esidence 6 🗸 Other	: Scene
1 of Vital Records, ling Phystian: The law requir After this certificate has been si funeral director, page 2 should I	<u>و</u>	1 Ves 2 No 28a. Date of Injury 28b. T	ime of Injury 28c. Injury at Work?	28d. Describe hov		
ion tendin eath. lor: A	atio	1 Natural 5 Pending FOUND: FOUND: 2 Accident Investigation	1 103 2 4 110	Subject shot		
Division tal or Attendii rs after death. al Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, far	m, street, factory, office building, etc.	or Town, Stat	te)	ral Route Number, City
Divi ospital or hours afte meral Div		4 V Homicide determined (Specify) Single Family He 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, dea		1	iall Road, Bryans R	
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	d at the time, date an	d place, and due to th	e cause(s)
To with	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moi	nth, Day, Year)
		My ( ) my	O.C.M.E.		July 21, 2009	
FRA		30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner	111 Penn Street, Baltimore,	MD 21201		
1/D X	ate	Russell Alexander MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year) 32. Registrer's Signature	TITT CHIT Officer, Datamore,			
Regist		JUL 2 4 2009 Leneur D.	backer			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 25am ul /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 T F Hours 216-06-7082 30 **Director** Apr 9. Cambodia Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director Dorchester 1X Yes 2 No other traumatic event, the Medical Examiner must be notified Maryland Cambridge 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? items 23a or 204 South Regulator Drive 21613 USA death y Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Specify: Asian 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant II University College 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Chan Navy Tuon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Clark - Husband 204 South Regulator Dr., Cambridge, MD 21613 permit. Pages 1 and Department of Healt Important: If item 2: any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/25/09 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Door tenter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** abdomina Compartmen /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that i Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death Ectopic pregnancy completely filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 12 Natural 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Director: After 5 Pending investigation hours after death. 2 Accident 1 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 MD and address of person who completed cause of death (Item 23a) (Type, Print) UROWSK 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month July Day Yea 1 / 2009 **Physician** 10:45 PM Carpenter Mae ula /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Wicomico Salisbury Wicomico Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□M 2**X**F 225-56-6683 June 16, 1941 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 1 ☐Yes 2 No Princess Anne Maryland Somerset Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21853 U.S. A Brownstone 11375 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □ Yes 2 No 3altimore, Maryland 21215-0036 Specify. Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Peninsula Regional Medicter Nursing 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tull Lee Harmon volia ISAAC P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd. Princess Anne, Md. 21853 Brownstone Arthur Carpenter - husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State Princess Anne, Md. 7125/09 4 □ Donation 5 □ Other (Specify) John Wesley Cemetery 22. Name and Address Facility Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee Princess Anne, And. 21853 Attho E. Ward 30639 Hampden Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \) 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Be Completed by 2 🗌 No 3 Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 2 4 No 25. Was case referred to medical examiner? funeral director, 26. Place - Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 5 Pending investigation 1 ∏ Yes 2 ∏ No n 24 hours after death.

ne Funeral Director; A
bletely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar yappa, MD 61

JUL 12 2009

Maesha Thimmarayappa,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lucia A. Jak

614 Eastern Shore Drive, Salisbury, MD 21804

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ugustine DeGrace	State of Maryland / Department of Health and Mental Hygiene  - For State  Certificate of Death  Reg. No. 2009 2530											
Physician/ ledical Examiner	1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of	Death										
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  5t. Agnes Hospital  4c. County of Death  Baltimore											
Funeral Director	5. Social Security Number 217–90–2746 6. Sex 1 Months Days Hours Min. 06/01/1968 Foreign Country) 9. Birthplace (State of Birth (MM/DD/YYYY) 9. Birthplace (State of Birth (MM/DM/DD/YYY) 9. Birthplace (State of Birth (MM/DD/YYY) 9. Birthplace (	ate or										
aryland 8a-f show any at once,	MD Howard Elkridge 1 Ye	e City Limits										
the Maryland a or 28a-f sh tiffed at onc	10e. Street and Number 6307 Sandpiper Ct. 10f. Zip Code 21075 10g. Citizen of What Country? USA											
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  The street of Health and Mental Hygiene in the "natural", or items 23a or 28a-f shown or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	3 Widowed 4 N Divorced III Yes, Give Year   985 – 1987   1 Yes 2X No specify: Specify: Specify:	Black,										
5-0036 ed within 72 hour stygiene "hatu hatu he Medical Exau Completed	during most of working life. DO NOT use retired)  12 College (1-4 or 5+)  Traffic Enforcement Civil Service	l Service										
nore, MD 21215-0036 ages I and 2 should be filed within 72 nt of Health and Mental Hygiene. It: Filtem 27 is marked other than other traumatic event, the Medical To Be Comple	Luther L. Jones Sandra Dorsey											
MD 21 nd 2 should thith and Me m 27 is ma aumatic ev	Sandra Dorsey / Mother 6307 Sandpiper Ct., Elkridge, MD 21075											
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withit Department of Health and Mental Hygiene. Important: If item 27 is marked other it injury or other traumatic event, the Med To Be Comy	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Mt. Carmel Cemetery  08/06/2009 Dundalk, MD	е										
Balti permit. Departri Imports injury c	21. Signature of Funeral Service Licensee M01452 22. Name and Address of Facility Rendon-Bailey Funeral Home 2818 E. Baltimore St., Baltimore, MD 2122											
Physician /Medical caminer	failure. List only one cause on each line.	mate Interval in Onset and Death										
er	Sequentially list conditions b.											
ansit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):											
50, te be executed ysician and burial - transi	X UNPENDED 23a,27, perME, g894 8/24/09 TT											
that the death certificate be executed by the attending physician and detached for use as the burial - training by Physician/Medical I	FFEMALE: 23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Da	Year										
i, P.O. E ires that the e signed by th I be detached d by Ph	1 Yes 2 ✓ No 3 Probably 4											
tal Records, Frian: The law requires certificate has been signector, page 2 should be Be Completed I	24a. Was an autopsy finding autopsy performed?  1 ✓ Yes 2 No 1 ✓ Yes											
f Vital Physicians er this certi ral director	25. Was case referred to medical examiner?  1											
Division o  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune- ledical Certification:	1 X Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined Homicide Homicide (Month, Day,Year) 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route or Town, State)	Number, City										
To the Hospi within 24 hou To the Funct completely fil	1 29a Certifier	)										
To with To Do	and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.  29d. Date signed (Month, Day, Y August 2, 2009	'ear)										
	30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
State Registrar												

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician /Medical

1. Decedent's Name (First, Middle, Last) Rolando Emelio Loret de Mola

2. Date of Death Day 23, July

3. Time of Death AM

10d. Inside City Limits

**Examiner** 

4a. Facility Name (If not institution, give street and number) Villa Rosa Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)

1 X M 2 □ F

4b. City, Town, or Location of Death Mitchellville

7:30 2009 4c. County of Death

Prince George's

**Funeral** Director

23a or 28a-f show

the Medical Examiner must be notified at

o.

"natural"

Hygiene.

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If them 27 is marked other the any injury or other trainmant.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

δ

ပ

Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

the Maryland

filed within 72 hours after death

21215-0036

Baltimore, Maryland

263-70-2061 Usual Residence of Decedent 10a State 10b. County 89 Yrs. 10c. City, Town or Location

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

January 27, 1920

 Birthplace (State or Foreign Country) Cuba

Maryland | Prince George's

Greenbelt

1 X Yes 2 □ No

10e Street and Number

10f. Zip Code 20770 10g. Citizen of What Country?

7921 Mandan Road, #102 11 Marital Status

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

USA 14. Race - American Indian, Black, White, etc.

16b. Kind of Business/Industry

1 Never Married 2 Married 3 Widowed 4 Divorced

1 ∏Yes 2 ⊠ No If Yes, Give Year or Dates:

1⊠Yes 2□No Specify: Cuban Specify: Hispanic

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+) 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Interamerican Foundation

Completed 17. Father's Name (First, Middle, Last) Be (

Accountant

18. Mother's Name (First, Middle, Maiden Surname)

Fernando Loret de Mola

19a, Informant's Name/Relationship (Type, Print)

Amanda Cebrian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Thelma Loret de Mola / Wife

7921 Mandan Road, #102, Greenbelt, MD 20770

7/24/2009

20a. Method of Disposition

1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A.

Alexandria, Virginia

Lewis H almon

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):

Vascular Dementia

Due to (or as a consequence of)

Due to (or as a consequence of) Hypertensive Cardiovascular Disease Years Years

Years

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 9 ☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 ☐ Yes 2 🖾 No 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

4 Homicide

29a. Certifier

1 X Natural 2 Accident 3 Suicide

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

Hospital:

28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

and manner stated. 29b. Signature and title of certifier

20108

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rakesh Arora, 14300 Gallant Fox Lane, Suite #222, Bowie, MD 20715

31. Date filed (Month. Day, Year)

32. Registrar's Signature

**ORIGINAL** 

Box 68760. o ٦. Records,

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and signed to Division of Vital filled in by the 24 hours a within 24 ho

To the Fune

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State Registrar

DHMH 17 Rev 1/2001

09-06	020	
Brian	Keith	Downs

9-06020 rian Keith Down	s		or Print in Blact of Maryland / D							gible	) T		
		1- For State Registrar		Certifica					Re	eg. No.	20	no	2530
Physicia Medical Examir	1//	1. Decedent's Name (First, Middle,Las Brian Keith Dov	ms			-			2. Date of Deat Month August 2,	Day 2009	Year		D853 hrs
		4a. Facility Name (if not institution, gives St. Marys Hospital	e street and number)		4	b. City, Tov Leonard		ation of De	ath		County of De t. Mary's	ath	
Funeral		5. Social Security Number 6. S 219-02-1458	ex 7. Age (In	yrs. last birt	hday)	If Under		Hours N	<b>Viin</b>	,	Fo	reign	
Director	-	Usual Residence of Decedent	M 2 F	42	Yrs.				June 1	8, :	1967	Country	Maryland
n with the Maryland ms 23a or 28a-f show any be notified at once,	Į	10a. State 10b. County  Maryland St. Mai		. City, Town									d. Inside City Limits Yes 2X No
faryland	~ L	10e. Street and Number	. y S	потту	ywood	10f. Zip C	ode		1		zen of What C	country?	>
death with the Maryland or items 23a or 28a-f she must be notified at once		24493 Oak Valley		7 110	40 141	206		la Oriala?	( Specify Yes or No		SA	morioon	Indian, Black,
it at	Funeral	11. Marital Status  1 Never Married 2 X Married	12. Was Decedent Eve Armed Forces? 1 Yes 2						uerto Rican, etc.) White,			c.	
s after c	by F		If Yes, Give Yeer or Dates:		1	Yes 2X		, ,	of work done		Specify: (ind of Busine	Whi	
72 hour	eted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or 5+)		during m	ost of worki	ng life. DC	NOT use	se retired)				ŕ
0036 within giene. her tha	Completed	12 17. Father's Name (First, Middle, Las)	1	She	eet l	Metal			Construction  Name (First, Middle, Maiden Surname)				.on
215- be filed intal Hy rked of	Be	Ralph W. Downs, S	Sr.				P	atrio	cia A. Pa	rke	er ; City or Town, State, Zip Code)		
Baltimore, MD 21215-0036  bemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f shinging or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Amy M. Downs/Wife							or Rural Route Nur ane,Ho11				
Baltimore, MI permit. Pages 1 and 2 s Department of Health at Important: If item 27 injury or other traum:		20a. Method of Disposition  1 XBurial 2 Cremation 3	Removal from State	cremat	ory or ott	ition (Name her place)		AU	igust 7,	1	Location - Cit	-	vn, State
Itimo ait. Pag artment ortant: ry or ot		4 Donation 5 Other Specification 21. Signature of Funeral Service		Queen		Vame and A			2009 Brinsfiel	1	Helen,		D A
Balt permit. Departi Importinjury		12t Gelet	MO	0817	30	195 Ti	nree	Notch	Rd., Ch	ar1	otte Ha	a11.	MD 20622
Physician /Medical		23a. Part I. Anter the disease, or comfailure. List only one cause on e	ach line.							rest, she	ock, or neart		Approximate Interval Between Onset and Death
`xaminer		Immediate Cause (Final disease or condition resulting in death)	Alcohol and oxycodone intoxication  Due to (or as a consequence of):									$\dashv$	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	Due to (or as a consequence of):									
ed isit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):									
execute an and al - trar	_ ,	X UNPENDED	AMENDED 23a,	211,27	,28a	-f,pe	rME,	g894	8/10/09	TT			
760, ficate be ex g physician s the burial	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		_	etal death	3	Ectopic pre	egnancy	23	d. Date of del	livery Day	Year
Records, P.O. Box 68760, The law requires that the death certificate be execute in the second crate has been signed by the attending physician and page 2 should be deached for use as the burial - trans	Physician/Medical	past 12 months?  1 Yes 2 No 9 Unknow	4 Pregnant at tim			ther (Specif		, = 0.0p.10 p.11		1		,	
S, P.O. Box Jires that the death 1 signed by the atter d be detached for u	/ Phy	Part II. Other significant conditions	3 OHKIOWII	it not resultin	ig in the i	underlying o	ause give	en in Part I.				te to the	cause of death?
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tal Rec tian: The l certificate b	e Co	25. Was case referred to medical				26	6.Place of	Death (Ch	1 Yes	2	10 1	Yes	2 No
Vita hysicia this ce	To B	examiner?  1  Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/C			<u></u>		ursing Home 5		(annual	Other:	
n of iding Pl h. : After		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)		Time of		3c. Injury a	at Work? s 2 <b>X</b> No	28d. Describe	how in	jury occurred		
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cortifi completely filled in by the funeral director.	1							28f. Location or Town,	ation (Street and Number or Rural Route Number, City own, State) 24493 Oak Valley Ln - ywood, MD				
le Hospit n 24 hour e Funera letely fill		29a. Certifier 1 Certifying Physi	cian: To the best of my kr	nowledge, de	eath occu	rred at the t	ime, date	and place,	and due to the cau	ıse(s) a	nd manner as	s stated	cause(s)
To the within 2 To the complet	Medical	29b. Signature and title of certifier	and manner stated.	auon and/or	vesuya		License r		at the time, date		. Date signed		

August 3, 2009

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner

Registrar

State 31. Date filed (Month, Day, Year) AUG

State Registrar 130

B. park

32. Registrar's Signature

MUNSHI MD

31. Date filed (Month, Day, Year)

HOSP RD PRINCE FREDERICK

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Voar **Physician** 2009 1033 A George Tweedy Ginn August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ceci1 715 Knights Corner Road E1kton If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea DEC 31, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1X M 2□F **Funeral** Months Delaware 1918 Director 222-09-4338 90 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10b. County show 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be a United States 715 Knights Corner Road 21921 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ntt: If item 27 is marked other than "natural", or ite 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Accounting and Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Tax Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Atwell ၉ Fred A. Ginn, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 715 Knights Corner Road, Elkton, MD Ruth P. Ginn/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 5, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 0 Department of Important: If any injury or once, 4 □ Donation 5 □ Other (Specify) 2009 Chesapeake City, MD Bethel Cemetery 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATH **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has b irector, page 2 s autopsy performe death? 1 □ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Hesidence 6 ☐ Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident neral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) and title of certifier 29b. Signatur DOD6346 hesso 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vanessa Villar, M.D., 361 Fair Hill Drive, Elkton, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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			5. Social Security N			ge (In yrs. i	last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign	
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		-	Usual Residence o	f Decedent		100 Cit	y, Town or Lo	cation				1	0d. Inside City Limits	_
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he Ma	28a-f	Director	10e. Street and Nu					10f. Zip Code		1	0g. Citizen of V	Vhat Cour	ntry?	T
with t	a or			tinel Dri	ve #204			2081	5		United	Stat	es	
eath	ns 23	Funeral	11. Marital Status	ICITICE DE	12. Was Deceder	t Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Sp	pecify Yes or No-		e - Ameri	can Indian, etc.	
fterd	r iter			ried 2 Married	Armed Forces 1 Tyes 2 If Yes, Give		1	1 ☐Yes 2x No	Specify:	,		. Whi		
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and 2	n 27 I			Healey/	Wife	Took !		Sentinel		Date Date	20c. Location	- City or T	own, State	_
Ses 1	if iter		20a. Method of Di		☐Removal from Sta	te Geo	cemetery, cre	osition (Name of ematory or other pla on Univer	sity July	7 20	Washing			
t. Pac	tant: ijury			5 Other (Spec		Mec				, -			vices,P.A.	_
	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "any Injury or other traumatic event, the Medical Evaluation rulet be rediffied at once.		21. Signature of F	Funeral Service Lice	C of	1009		9013 Anna					·	
			23a. Part 1. Enter	the disease, or co	mplications that caus	sed the dea							Approximate Interval Between	
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70	# # # # # # # # # # # # # # # # # # # #	iner	Sequentially list of if any, leading to cause. Enter Und Cause (Disease	immediate derlying	Due to (or	as a conse	quence of):							
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0	ang ruysician.	Lü	27. Manner of De	eath 5 Pending	28a. Date of (Month)	lnjury , <i>Day, Year)</i>	28b. Time Injur	y   W	ork?	28d. Describe	how injury occu	urrea		
Sio	eath. eath. tor: A	cati	2 ☐ Accident	invention		d Injury - At	home farm	M 1 street, factory, office	∐Yes 2 □No	28f. Location	(Street and Nur	mber or R	ural Route Number,	_
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_	to the hospital of Attending Frlystoan. within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier	1 CertifyIng	Physician: To the base	oest of my k	nowledge, de	eath occurred at the	time, date and pla	ce, and due to the	e cause(s) and	manner a	as stated. e to the cause(s)	
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i	Vithi To the	Σ	29b. Signature a	and title of certifier	#10 - MA	0		29c. Lice	D 16/6/9	>	July	_14	2009	
	2		- Carr	Jurios	1001		10m (0m) /T	Drint\			0		01000	
			30. Name and a	ddress of person w	ho completed cause	of death (II 1940	Frank	Plus Squ	au Dnice	Notte	gham,	MD	21236	
	St	tate	31. Date filed (A	Month, Day, Year)	32. Re	gistrar's Sig	nature	1. 1. 1						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** July 22, 1:45 A M Bella HAUSMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) Aug. 15, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 917 1 □ M 2 🗓 F Months Days Delaware 91 182-01-4478 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ir than "natural", or items 23a or 28a-f show Rockville 1 Nes 2 No Montgomery Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20850 13704 Valley Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married white 1 □Yes 2 XNo Specify: Specify: þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Religion Office Manager i. Pages 1 and 2 should be filed w trent of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Banks Louis Simon ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 13704 Valley Drive, Rockville, MD 20850 19a. Informant's Name/Relationship (Type. Print) Steven Hausman, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or ott 1 X Burial 2 ☐ Cremation 3 X Removal from State Lower Moreland, PA Shalom Memorial Park : 07/24/09 4 ☐ Donation 5 ☐ Other (Specify) M01008 21. Signature of Vineral Service Licenses Törchinsky Hebrew Funeral Home Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. VISLAZI Immediate Cause (Final oronary **Physician** seal disease or condition resulting in death) /Medical to (or as a consequence of) Examiner ROLL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for s a consequence of): Examiner avs Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Dav 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Tes 2 🔲 No

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

reral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760, P.O. Division of Vital Records, Hospital 24 hours a To the I within 2

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Natural 2 Accident 5 Pending investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Medical 29b. Signature and title of certifier

Nicole Wetere,

and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

20850 9901 Medical Center Drive, Rockville, MD

State Registrar

Registrar's Signat 31. Date filed (Month, Day, Year) 32 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:00 PM 21 2009 DAVID JEROME HERSH JULY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S 330 COVE ROAD QUEENSTOWN 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**X** M 2□ F Months Days Hours Min. OCTOBER 26, 1945 PENNSYLVANIA Director 185-36-0186 63 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director **MARYLAND** QUEEN ANNE'S **QUEENSTOWN** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 330 COVE ROAD 21658 Funeral hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No If Yes, Give Year or Dates: Specify: WHITE Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) GAS COMPANY 5+ CHEMICAL ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First, Middle, Last) Be 2 should be fin and Mental I is marked of JEROME C. HERSH ESTHER M. MORGAN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sh of Health ar VICTORIA HERSH/WIFE 330 COVE ROAD, QUEENSTOWN, MARYLAND 21658 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If iter
any injury or ott 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other Specify) JULY 22 CHESAPEAKE CREMATION 2009 STEVENSVILLE, MARYLAND 21. Signature of Funeral 5 22. Name and Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. vice Licensee 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death he disease, or complications art failure. List only one caus hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. shock, or heart failure. Immediate Cause phag **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to increalate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No signed by the a Ö 9 Unknown <u>a</u> 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F safter death. I Director: After d n by the funera After 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled n by 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and tale of certifier UnD.

DHMH 17 Rev 1/2001

State Registrar Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bestgate Rd. Svite300 Annapolis, Md.

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 24, 2009 1:47 PMm **Physician** Harris В. Burlean /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital 8. Date of Birth Month, Day, Year March 16, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** o, 1932 Virginia 1 □ M 2 ⋤ F Months Days Hours Min. 77 231-34-9442 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Marical Examinar mast be refilled at 1 ☐ Yes 2 No Director Fort Washington Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20744 720 Amer Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2∰No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian 11. Marital Status 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 Ho Specify: Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Pastry Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosa Hudson Wood Branch Linnie Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trau 720 Amer Dr., Ft. Washington, MD 20744 Sheryl B. Bellamy - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 27, 2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Powhatan, Virginia Mt. Zion Baptist ChurchCemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee Georgen Pad Kalas Puneral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Pary. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AThenosclevoti /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Demes Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Atter this certificate has been stuneral director, page 2 should in Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2, No After this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 🖸 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification: To To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01-26-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) livingston nu Holft warkington MO207(1) 11201 MO 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day Physician 22, 2009 1:20 PM James A. Jones, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert County Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Year) Days 1 XM 2□ F Hours 84 578-38-5234 VA 02/14/1925 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Expressioner must be notified at Director MD 1 ☐ Yes 2 No Calvert Huntingtown 10f. Zip Code **20639** 10e Street and Number 10g. Citizen of What Country? **USA** 775 Carson Road permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Mydical Eventine must once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Owner Electronics Distribution 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Dell Walsh Lester Boyd Jones ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3520 Howard Drive, Port Republic MD, 20676 Sandra Feinberg/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 07/27/09 Rockville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of F neral Service Niconsee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A 8125 Southern Maryland Blvd. Owings, MD 20736 Nisa M. weants 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPINATION /Medical Due to (or as a consequence of): Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of): Records, P.O. Box 68760, requires that the death certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy

☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 ☐Yes 2 ☐ No 1 □Yes Division of Vital 2 No Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50233 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Dr. Glynis A. Moody, M.D. 10845 Town Center Blvd. Dunkirk, MD 20754 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Denus

DHMH 17 Rev 1/2001

09-05850 David Kackley

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		1- For State Registrar	Certificate o	f Death			leg. No.				
Physicia edical Exami	an/	Decedent's Name (First, Middle,Last)				Date of Dea     Month	2. Date of Death 3. Time (				
1		4a. Facility Name (if not institution, give street and number) 1701 Seward Road		4b. City, Town, Chester	or Location of I	Death	4c. County Queen				
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 M M 2 F	ear If Under 2 ays Hours	Min.	Country						
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
Maryland 28a-f show d at once,	to	MARYLAND QUEEN ANNE'S CHESTER							1 Yes 2 No		
death with the Maryland or items 23a or 28a-f sho must be notified at once	Il Director	10e. Street and Number  1701 SEWARD ROAD		10f. Zip Code <b>21619</b>				ED STA	ATES		
<b>→</b> = 1	Funeral			Yes, specify Cub	an, Mexican, P	? ( Specify Yes or No uerto Rican, etc.)		ite, etc.	an Indian, Black,		
2 hours after "natural", o Examiner "	ğ	3 Widowed 4 Divorced of Divorced of Dates:  15. Decedent's Education (Specify only highest grade company)	11	Yes 2 X N		nd of work done	Specify: 16b. Kind of B	LTE dustry			
	Completed	Elementary/Secondary (0-12) College (1-4 or 5-	+) during m	nost of working li		PLUMB1 CONSTR					
15-003( filed within I Hygiene. Id other than	e Co	17. Father's Name (First, Middle, Last)				Name (First, Middle,		e)			
21215-0036 and be filed within 7 Mental Hygiene. marked other than it event, the Medica	To B	HOLBERT KENNETH KACKLEY  19a. Informant's Name/Relationship (Type, Print )		g Address (Str		EL IRENE I er or Rural Route Nu		wn, State, 2	Zip Code)		
MD d 2 sho lith and n 27 is		TIM KACKLEY/SON				CHESTER,					
Baltimore, MD Z bermit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n njury or other traumatic		20a. Method of Disposition  1 Burial 2 Toremation 3 Removal from State  4 Donation 5 Other Specify:	SOMSET ME			JULY 31 2009	20c. Location	·	own, State		
Baltimo permit. Page Department o Important: injury or ott		21. Signature of Funeral Service Licensee	22. I FE	Name and Addre	ss of Facility	BEIN AND N	EWNAM F	UNERA	L HOME, P.		
Physician		23a. Part I. Enter the disease, or complications that caused to				D. CHESTE diac or respiratory ar			21619 Approximate Interval Between Onset and		
/Medical Examiner	1	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):									
	<u>.</u>	Sequentially list conditions, b									
	Examiner	identify it is any, leading to immediate and the consequence of it is a consequence of its account of									
recuted and - transit											
lal an	Medical	UNPENDED AMENDED									
8760, ificate be exigo physiciar is the burial		IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the 1 Live birth		etal death 3	B Ectopic p	regnancy	23d. Date of Month	of delivery Day	y Year		
Box 687 he death certific the attending p	Physician	past 12 months?	in a of death	ther (Specify)					,		
D. Be t the de by the	Phy	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause	e given in Part	I. 23e. Did t	obacco use con	tribute to the	e cause of death?		
ires that the signed by	d by	Lung disease				1 Ye	s 2 No 3	Probab	bly 4 🗹 Unknown		
ords  w requ as been 2 should	Completed	24a. Was an 24b. Were aut autopsy prior to comperformed? death?									
Rec The la ficate h	S	<u> </u>			_	1 Yes	2 ✓ No	death? 1 Yes	2 No		
/ital /sician vsician vis certi	e Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatien	t 2 ER/Outpatient		Other	Nursing Home 5	Residence 6	✓ Other: §	Scene		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death.  al Director: After this certificate has been signed by led in by the fameral director, page 2 should be detach	on: To	27 Manage of Death									
ision Attener er death rector:	icati	2 Accident Investigation 28e. Place of Inju	ury - At home, farm, stre		Yes 2 N		Street and Num	ber or Rura	I Route Number, City		
Divi	Certification:	3 Suicide 6 Could not be determined determined (Specify) (Specify)									
Division of Vital Rec To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exam and manner stated.									
	æ	29b. Signature and title of certifier	•	29c. License number			29d. Date signed (Month, Day, Year)				
12		Carol Hallai	oth (Hom 22-)	0.0	C.M.E. 		July 27, 2	υ09 ————			
		30. Name and address of person who completed cause of de Carol Allan, MD Assistant Medical Exam		Street, Baltir	nore, MD 2	:1201					
St	ate	31. Date filed (Month 1949, Y277 2009 32. Jegistrar	s Signature	west .	<u>-</u>						

Physician
/Medical
Examine
Funeral

**Physician** /Medical Examiner

Box 68760, P.O. Division of Vital Records, After 1

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 19,2009 Pauline 1329 Lombardo 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Olney
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 1,1929 Olney Montgomery Montgomery General Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 1 M 2 XF 002-20-7430 80 NH Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4-100nc. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 ☐ Yes 2X No Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3701 International Drive 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ∐Yes 2 🔀 No White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christos Chalogias Thomae Tsubleca 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Steven Lombardo/Son 6928 Barrett Lane Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 5 ☐ Other (Specify) 7/27/2009 Manchester, NH 4 ☐ Donatio Pine Grove Cem. 21. Signature of Funeral Service PHINDIP ADERTMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin. Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 I I Inknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ne 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 24 hours after deat 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29c. License number 29b. Signature and title of certifier 0057630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anuradha Arun M.D. ME 31. Date filed (Month, Day, Year) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ephanie Marratto		State of Maryland / Department of Health and Mental Hy - For State Certificate of Death		Reg. No	20	00 2531
Physician		tegistrar 1. Decedent's Name (First, Middle,Last)	2. Date of De	ath	• • • •	3. Time of Death
ledical Examine	r	Stephanie Michele Marratto	Month July 17, 2	2009	c. County of Deat	1135 hrs
	4	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital Baltimore		ľ	c. County of Deal	
Funeral	ŧ	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24Hrs		Birth(MN	//DD/YYYY) 9. Bii Forei	rthplace (State or
Director		217-25-6371 1 M 2 KF 21 Yrs. Months Days Hours Min.	Apr	.4,	1988	buntry) MD.
<u>,                                    </u>	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
ow any		MD Montgomery Gaithersburg				1 Yes 2 X No
the Maryland a or 28a-f show	<u> </u>	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Cou	untry?
the h		31 Landsend Drive 20878			USA	
th with	<del>-</del> □	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Single Forces? 14. Wester Married 2 Married Armed Forces? 15. Was Decedent of Hispanic Origin? (Single Forces)	pecify Yes or No Rican, etc.)	NO-	14. Race - Ame White, etc.	rican Indian, Black,
er deat		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:			Specify: W	hite
ours afi	<u>-</u>	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done	16b	. Kind of Business	/Industry
n 72 h n 72 h	ompieted	Elementary/Secondary (0-12) College (1-4 or 5+) 2 Student	,		Colle	ege
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	<u> </u>	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle	, Maide	en Surname)	
215 be file ntal Hy rked o	8	Charles Pierce Marratto Miche			Audley	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	<u> </u>	19a. Informant's Name/Relationship (Type, Print)  Charles P. Marratto/Father 31 Landsend Drive				
md 2 sho lealth and 2 ten 27 is traumati	H	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		c. Location - City of	
nore	1		23/20	0 🖢	Germar	ntown,Md
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	ŀ	21. Sign three of Funeral Serice License 221. Sign three and Address of Facility LD	I FUN	ERA	L SERVI	CE,P.A.
	4	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	lvd.S	ilv	er Spri	ng, Md20910 Approximate Interval
Physician / Medical		failure. List only one cause on each line.	or roopa.a.,			Between Onset and Death
aminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries with complications  Due to (or as a consequence of):				
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
		Course. Enter Underlying Cause (Disease or injury that initiated				
Busit ed	EX	events resulting in death) Last  Due to (or as a consequence of):  d.				
50, te be executed ysician and burial - transit	edical	UNPENDED AMENDED				
760, icate be physici	Ĭ,	IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregram	nancy		23d. Date of delive Month	ery Day Year
Box 6876( e death certificate the attending phy ed for use as the b	Physician/M	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	ancy	1	Month	
Boy le death the att	hysi	1 Yes 2 No 9 V Unknown g Unknown	23e Di	d tobac	co use contribute	to the cause of death?
P.O.	g B	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		Yes 2		robably 4 🗸 Unknown
ords, P	Completed		24a. W	as an		autopsy findings available o completion of cause of
e law i	E I		pe	erformed es 2	d? death	?
tal Recitian: The certificate rector, page	Be C	25. Was case referred to medical 26.Place of Death (Chec	k only one)			
Vita	의	1 🗸 Yes 2 No	sing Home 5		injury occurred	her:
Division of Vital Records, tal or Attending Physician: The law requires after death. The this certificate has been so led in by the funeral director, page 2 should led in by the funeral director, page 2 should be a second		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury  28b. Time of Injury  28b. Time of Injury  28c. Injury at Work?  2013 hrs  1 Yes 2 ✔ No	Subject p	asser	nger of vehicle	e involved in motor
risio r Atter er deat irector irector	iga iga	2 V Accident Investigation 28e, Place of Injury - At home, farm, street, factory, office building, etc.	28f. Locatio	n (Stre	et and Number or	Rural Route Number, City
Division pital or Attent ours after death ceral Director:	Certification:	4 Homicide determined (Specify) Major Road / Highway	-		e) rd Road , Urban	
		29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and the death occurred at the time, date and place, and one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the o	ause(s ate and	) and manner as s i place, and due to	tated. o the cause(s)
	Medical	29b. Signature and title of certifier 29c. License number			9d. Date signed (i	
3			DOME	J	luly 20, 2009	
	}	30. Name and address of person who completed cause of death (Item 23a)	MD 04	204		
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimo	ore, MD 21	201		
Sta Registi	ate	THE DA SOURCE PRODUCTION AND ANALYSIS				

Ammended Box 19B per F.D. Carroll County WSH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland					Mental H	ygien	е		
			Registrar			Cer	tificate	e of L	eatn	10 D-t/ D	Reg. N	o. 201	19	25319
	Physici	an	1. Decedent's Name (First, Middle, Last)							2. Date of D Month July	D:	2000	ar	3. Time of Death
	/Media		Jane Marie McKenny  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								16 2009 7:50 p <sup>N</sup> 4c. County of Death			
1	Examir	ıer				1. CL			zille	iur	1		urro	311
	Funeral		Brinton Woods Nur 5. Social Security Number 6. Sex		ge (In yrs. la		If Under	1 Year	If Under 24 Hr	s. 8. Date of B	irth			ace (State or Foreign try)
	Director		213-20-7590	M 2√2 F	83	Yrs.	Months	Days	Hours Mir	Jan	13	1926	Count	MD
	pu ,		Usual Residence of Decedent		10= City	Town or Loc							140	Od. Inside City Limits
	aryla shov	5	10a. State 10b. County  MD Carro	11	Toc. City,		stmins	ster						1 □ Yes 2 □ No
	the M	ect	10e. Street and Number	) <u></u>		7,00	10f. Zip				10a. C	itizen of What	t Count	T.7
	with the	٥	3400 Pine Circle	North			101. 2.10	21:	157		l rogi o		JSA	,.
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the M. deol Evain inc. ust be rediffed at	Funeral Director		2. Was Decedent		i. 13. y	Vas Deced	ent of His	spanic Origin? (	Specify Yes or N	lo-	14. Race - A	America	
9	or ite	Ē	1 ☐ Never Married 2 ☑ X arried	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	? <b>_</b> No		_ ` `		, Mexican, Pue	rto Rican, etc.)		Black, W		
93	iral",	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			□Yes 2	- 1 <b>3</b> (140	Specify:			Specify:		White
7	72 h "natu	ete	15. Decedent's Educ (Specify only highest grade	ation completed)	¥	16a. Deced (Give	kind of wor	k done d	urina most of wo	orking	16b. I	Kind of Busine	ess/Ind	ustry
121	within ene. <b>than</b>	Ę	Elementary/Secondary (0-12)	College (1-4or	5+)	IITE. L	NOT us Homer	,				Own	Hom	ne
d 2	filed Hygir Sther		17. Father's Name (First, Middle, Last)				HORRE			ame (First, Middl	e, Maide		1101.	
an	ld be lental ked c	To Be	John A. Miner						Caro.	lyn A. W	7ilsc	n		
Maryland 21215-0036	shou and N s mar		19a. Informant's Name/Relationship (Typ	oe. Print)		19b Mailin	g Address	(Street a	nd Number or F	Rural Route Num Westminst	ber, City	or Town, Sta	te, Zip	Code)
Σ	and 2 ealth n 27 i		Clayton T. McKenny	/husband		3400	) Pine	e Cin	lce No.	th Wes	unii.	ster,	MD	21157
ore	Jes 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Pla	ace of Dispos metery, crem	sition (Nam atory or ot	ne of ther place	07/2	2372009		ocation - City		
altimore,	: Pag tment tant; tant;		4 Donation 5 Other (Specify)		Gar				eterans		1	ings M		s, MD
Baj	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exali, increasit by nufficed at once.		21. Signature of Funeral Service License	e						ome and				01155
			23a. Part 1 Enter the disease, or complic	ations that source	d the doub					oad Wes		ster,		21157
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each l	ine.		~	e or ayırıç	g, such as cardi	ac or respiratory	arrest,			Approximate Interval Between Onset and Death
-, F	hysician /Medical		disease or condition resulting in death)	Due to (or as	/	ellell	-0^						-	
	Examiner			Due to (or as	s a consequ	erice or).								
	B +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequence in death).	Due to (or as	a conseque	ence of):								
	ecuter ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
90,	cate be executed ohysician and the burial-transit		resulting in death) cast	Due to (or as	a conseque	ence of):								
		dical	d										+	
9 X	certif nding se as	/Me	IF FEMALE:	3c. If yes, outcome	e of pregnar	ncv						23d. Date of	f dolivo	in.
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant a	2 🗌 Fetal	death 3□	Ectopic pr Other <i>(sp</i> e					Month		Day Year
P.O.	t the c by the ached	hysi	9 Unknown	9 Unknown										
S,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions con	tributing to death t	but not resul		, ,	ause give	n in Part I.	23e. Did	l tobacco	use contribut	te to th	e cause of death?
ğ	/ require been się should b	ed	Collegen	MSWER	1.10	Slaw			·	. 10	]Yes 2	2 □ NO 3 □	Prob	ably 4 ☐ Unknown
ပ္ပ	e law requir has been s je 2 should	Completed								24a. Wa	s an opsy	24b. Wer	e autop	osy findings available npletion of cause of
<u>~</u>	ate h	Con	performed?   death?   1   Yes   2   No   1   Yes									th?		
Vite	ician: The certificate ector, pag	Be	25. Was case referred to medical examiner?	ospital:				Otho		eath (Check only	one)			
o d	Physician: r this certific ral director, p	<u>ا</u>	1 Yes 2 1 No 1 27. Manner of Death	1 ☐ Inpati		R/Outpatien 28b. Time of		Othe Bc. Injury	4 Lef Nursing	Home 5 ☐ Re			Specify	()
0	Attending F r death. ector: After by the funer	tion	1 Matural 5 Pending 2 Accident investigation	(Month, Da		Injury	M	Work	?a ′es 2 ⊡No	20d. Describe	o now mj	ary occurred		
Division of Vital Records,	or Attenc after death Director:	ifica	3 Suicide 6 Could not be	28e. Place of In	jury - At hor	ne, farm, stre	et, factory,	office		28f. Location	(Street a	ınd Number o	r Rura	I Route Number,
ō.	safter safter al Direction by	Certification: To	4 Homicide determined	building, e	тс. (Бреспу,	,				City or To	own, Sta	(e)		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	cal (	29a. Certifler 1 Certifying Phys (Check only 2 Medical Examir											
	the hin 24 the F	Medical	one)	and manner s	tated.	.c.r siluroi illi	_			canod at the tilli				
	29b. Signature and title of certifier  29c. License number						29d. D	ate signed (N	rontn, l 9	vay, rear)				
	red		y your la					200	0006		-	ti wio	1	
1	10		30. Name and address of person who con		death (Item	23a) (Type, I	rint)	chen	by Rd	- Elle	zer la	e de	)	21484
	Sta	ite	31. Date filed (Month, Day, Year)	1	rar's Signati	dre ,		/	/ /			/		t
	Registr		JUL 21 200	9 Dene	w K	9. 100	Mal							

09-05820 Ruth Mallory

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2009 25320

Control   Cont		1- For State Certific Registrar	icate of Death	Reg. No.							
TOTAL MALLORY  Accilipt sear forcemation, pive stress and sureful Decider's Community Hospital  Function  Director	Physician/	Physician/ 1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  1. Decedent's Name (First, Middle,Last)									
Doctor's Community Mospital    Community Mospital	Medical Examiner	RUTH MALLORY		July 25, 2009 1917 1118							
STORE   Comment   Commen											
Section   Company   Comp	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign							
The control of the co		579 44 0593 1 M 2 🚁 96		OCT 16 1912 S.C.							
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The property of the property o	d with with the Me	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surname)							
TOWN ALLEN/COUSIN  10800 LEGEND MANOR LANE GLENN DALE, MD  200, Method of Disposition, There of Design and Authority of State  200, Method of Disposition, The State  200, Man Allen/Cousing The Man Authority of	215 oe filk ntal H iked c	UNKNOWN									
The state of Deposition (Name of Deposition (	ID 21: 2 should be and Mer 27 is mar To	19a. Informant's Name/Relationship (Type, Print )	19b. Mailing Address (Street and Number or F 10800 LEGEND MANO	Rural Route Number, City or Town, 30, 100 de) R LANE GLENN DALE, MD.							
The state of the s	- p = = =	20a. Method of Disposition 20b. Pla	ice of Disposition (Name of cemetery,	Date 20c. Location - City or Town, State							
The state of the s	DOF Higgs I ht of F	RIV	matory or other place) ERDALE PK. CREM. 7	//29/09 RIVERDALE MD.							
23a. Fat I. Enter the disease, or complications that caused the death. Do not enter the mode of syng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  1	Itin		22. Name and Address of Facility	20010							
Table 1. District one cause on each line.  The state of the cause of t	Dem Perm Dep Imp		WATSON F H 3435	14th ST N.W. WASH. DC							
Medical Saminer  Medica	Physician	23a. Part I. Enter the disease, or complications that caused the death. D	o not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart Approximate Interval Between Onset and							
Due to (or as a consequence of):  Sequentially list conditions  Group the resulting in death)  Sequentially list conditions  Laure. Enter Underlying Cause.  Character of ringy that introduced overtal resulting in death)  Late of long as a consequence of):  Due to (or as a conse			ardiovascular disease								
The following property of the	xaminer	or condition resulting in death)  Due to (or as a consequence of):									
Course. Enter Underlying Cause (Chescharity 1 and 10 and 1		Sequentially list conditions, b									
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XUNPENDED   XMENDED   23a,27,28a=f, perME, g894 8/25/09 TT	xa	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Yes 2  No 9  Unknown	ecuted and - trans	0.0007.0	9. f parMF c80/ 8/2	5/09 TT							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Yes 2  No 9  Unknown	be exu	XUNPENDED AMENDED 23a,27,2	6a-1, perme, g694 6/2.								
29b. Signature and title of certifier  29c. License number O.C.M.E.  July 26, 2009  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	760 icate g phys the b										
29b. Signature and title of certifier  29c. License number O.C.M.E.  July 26, 2009  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	certif	past 12 months?    Pregnant at time of deat	h —	linoral Say							
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29b. Signature and title of certifier  29c. License number O.C.M.E.  July 26, 2009  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	res th										
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29b. Signature and title of certifier  29c. License number O.C.M.E.  July 26, 2009  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	/ita	examiner? [Hospital: , , , , , , , ]									
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29b. Signature and title of certifier  29c. License number O.C.M.E.  July 26, 2009  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	Division Division of the control of	4 Homicide determined (Specify) nursing	Greenbelt, MD								
29b. Signature and title of certifier  29c. License number O.C.M.E.  July 26, 2009  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	Host 24 ho stely f	d due to the cause(s) and manner as stated.									
29b. Signature and title of certifier  29c. License number O.C.M.E.  July 26, 2009  30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  State 31. Date filled (Month, Day, Year)  32. Registrar's Signature	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated.										
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Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		I lande Hallan	O.C.M.E.	July 26, 2009							
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		The state of the s									
Registrar AUS 1 4 2009 (Leuka B. August	Stat Registra	31. Date filed (Month, Day, Year)  AUG 0 4 2009	ver								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2340M **Physician** 300 a501 /Medical or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Hours Wa. (Month. Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number (In vrs. last birthday **Funeral** 1 M 2 F Maryland NONE Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Event men purition of 1 ☐ Yes 2 ☐ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Bla Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) it of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19b. Mailing Address (Street and Number or Rural Route Imber, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, LAUREL, MARYLAND 20708 M nother 9432 NICKLAUS LANE rffinlu 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition BALTIMORE CTOBER Burial 2 Cremation 3 Removal from State ō Department o Important: If i any Injury or once. 2,2009 4 Donation 5 Dother (Specify) HUSPITAL 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 57 AGNES Long BALTIMOREMARYLAND 21229 900 CATON AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final trems **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ № 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sh autopsy 1 ☐Yes 2 PNo 2 DN6 1 □Yes funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Α completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0058882 200 MD 30. Name and address of person who completed ca use of death (Item 23a) (Type, aton Avenue Battimore

State Registrar

31. Date filed (Mon.

Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Linda Mary McInnes July 31, 2009 12:00 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center For Hospice Care Towson 8. Date of Birth (Month, Day, Aug. 2, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Min. 1 □ M 2 🕇 F Months Days Hours Aug. 54 MD Director 220-68-5895 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 1 De la 2 □ No Director Shrewsbury PA York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 17361 U.S.A. 122 Raypaula Drive and 2 should be filed within 72 hours after death v lealth and Mental Hygiene. m 27 is marked other than "natural", or items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claims Manager Insurance Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lois A. Porter Chester F. Marciniak ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Raypaula Drive, Shrewsbury, PA 17361 Health James B. McInnes/Spouse Date 3, tem permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Cremation Direct
Service 1 ☐ Burial 2 X Cremation 3 X Removal from State York, PA 17401 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sanace License J.J. Hartenstein Mortuary, 24 Second Street, New Freedom, PA 17349 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** LUNI CANCES disease or condition resulting in death) /Medical Due to or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate each. Each of course Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 No 9 Unknown o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of The law cate has I page 2 s autopsy death? certificate 1 □Yes 2 1 ∐ Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To o this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Hospital or Attending 17 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No death. neral Director: / filled in by the f 2 Accident 6 □Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature JULY 31, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUL DEBERMAN, MO 6701 N CHAPLES ST, SUITE 4105 BALTIMORE, MD 21204 32. Registrar's Signature Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#7perFH, 7-24-09, BMW, MbCb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 2336 Pineda Calderon Joel Antonio Jul 7 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Waghinzbn Haventys mosso 140000 Dmer Koma C1 3 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 9 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1976 Months 1 ☑ M 2 ☐ F 23 33 Yrs. none Director Salvador Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Evandriar must be notified at Hyattsville Prince George' 1 □Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20783 El Salvador 8214 14th Ave. #301 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0036 1 XYes 2 □ No Specify White Specify \$ 3 🗌 Widowed 4 🗆 Divorced El Salvadoran Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpet Company Carpet Installer 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Pineda Campo Calderon Eugenio ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) of Health a Elba Pleitez de Ardon/wife 8214 14th Ave. #301 Hyattsville, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If iter any injury or oth once. 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Santa Ana, Santa Isabel Cem. 7/28/2009 4 ☐ Donation 5 ☐ Other (Specify) PHTE TPAdDS REMALDI FUNERAL SERVICE, P.A. Funeral Service Lig 21. Signatury 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) E/60 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending pl IF FEMALE ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Year signed by the a 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably this certificate has been sral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) 1¥Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 | Natural 5 ☐ Pending investigation Repairing microwave 2775 1 ☐ Yes 2 🗷 No Jul 17 2009 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide No seace 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and deep to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner system. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year) --

mo

Registrar's Signature

Park

20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Registrar AMEND#1perMD, 8-4-09, BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) Katherine Marina Patrikis 2. Date of Death Day Month Year **Physician** Maria Patrikis 22, July 2009 4:10 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🗗 F 578-50-5298 69 Yrs April 10, Director 1940 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Internation in the marked of the marked 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 XNo Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5212 Drake Terrace 20853 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Intermediate Public Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Vriones Stamatia Kerosis ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5214 Drake Terrace, Rockville, MD 20853 sition (Name of Date 20c. Location - City or Town, State Vassili George Patrikis/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■Burial 2 ☐ Cremation 3 ☐ Removal from State July 25 Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spring, MD 20901 TNU 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Breast Cancer disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Ye ar Day 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 1 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physician P.O. Division of Vital Records, To the Hospital of within 24 hours at To the Funeral D.

> State Registrar

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

Chitra Rajagopal, MD

29a. Certifier

18111 Prince Philip Drive, #329, Olney, MD 20832 31. Date filed (Month, Day, Year) 22. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D42452

29d. Date signed (Month, Day, Year)

July 22, 2009

State of Maryland / Department of Health and Mental Hygiene 🤈 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:10 A M 23 2009 July Gertrude Peller T. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Kensington Park Retirement Kensington 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🕅 F Yrs 13, 90 June 1919 056-09-9240 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic exercises. 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1. Yes 2√2 No Director Md. Montgomery Kensington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3618 Littledale Road 20895 Funeral Apt. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2**₽** No 1 □Yes 2X No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) G.W. University Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Flom Jacob Tofsky ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2047 Mayfair McLean Ct., Falls Church, Va. 22043 Karen P. Selwyn - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 7/24/09 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Dr., Alexandria, Va. 22315 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory arrest, **Physician** mont disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi) Examine law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🖾 No 5 ☐ Other (specify) P.O. I the 9 | Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy The perform certificate 1 ☐ Yes 2 ☐ No 2**\( \bar{\sqrt{1}}\)**No 1 □Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence Other (Specify) 1∐Yes 2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 1 📉 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Day, Year) 29c. License number 29b. Signature and title of certific 00051113 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 20100 correctict Are site 106 Schwe-tz

State

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JUL 272009

31. Date filed (Month, Day, Year)

MD

09-05666 Devin Quarles

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 25326

		- For State Registrar			-	Certi	ificate of	Death					Reg. No.	lo-va	. O O	of too	70 1
Physicia edical Exami	ın/	1. Decedent's Name  Devin I									1 -	Date of Dea Month July 19, 2	Dav	Year	3	Time of Death 2124 hrs	
euleai Exaiiii		4a. Facility Name (i	f not institution	n, give stre		er)	4	b. City, To					4c.	County of	Death		
		Calvert Men					4.4 fells alon N	If Under		If Under	24Hrs	8. Date of B			9. Birthr	lace (State or	
Funeral Director		5. Social Security N 579-15-8		6. Sex		Age (In yrs. las	30 Yrs.	A 4 41	Days	Hours	Min.	11/0			Foreign	try)DC	
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vith th s 23a		11. Marital Status			Was Deced	ent Ever in U.S	6. 13. Wa	s Deceden	t of Hispa	anic Origin	n? (Spe	cify Yes or N	10-	14. Race White		an Indian, Black	
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Baltimore, permit. Pages I ar Department of Hee Important: If ite	Ш	1 🕇 Burial 2			Removal from	State Ft	rematory or of	ther place)	Cem	etek	ry 7	//25/	0 9 1	Bren:	land	oa N	
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aminer:	0	Immediate Cause or condition resul	(Final disease	e a.He	ad and ne	eck injuries	0.									- Dodin	-
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Division of Vital Records, tal or Attending Physician: The law requires after death. After this certificate has been seled in by the funeral director, page 2 should led in by the funeral director, page 2 should led.	Certification:	3 Suicide		ould not be termined		of Injury - At h		reet, factor	y, office t	ounding, e	ic.	or Tov 1595 Pus	vn, State) haw Sta	tion Road	d, Sund	erland, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici cronnlerely filled in the funeral director.	S	4 Homicide 29a. Certifier	e	Sh. sister	To the best	of my knowled	dae death occ	curred at th	e time, d	ate and pl	ace, and	due to the	cause(s)	and mann	er as sta	ted.	
To the II within 24 To the F	Pedical	(Check only one) 2.	✓ Medical E	xaminer:0	n the basis o	of examination	and/or investig	gation, in m	y opinior	n, death o	ccurred a	at the time,	date and	prace, and	due to t	ie cause(s)	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** Elizabeth Radabaugh July 21, 4:35 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19351 Circle Gate Drive, #102 Germantown Montgomery 8. Date of Birth Month Day, May 29, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Year) 1946 1□M 2🕇F Months Days Hours Min. 215-46-1648 Maryland 63 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show her must be notified at 1 ☐ Yes 2 ☐No Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with innert of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Examinations 19351 Circle Gate Drive, #102 20874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐Yes 2X No Specify þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Receptionist Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Charles Williams Treva Leola Cameron ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Lee Radabaugh/Husband 19351 Circle Gate Drive, #102, Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State July 2 2009 23, 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once, Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary Artery Disease Physician /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Diabetes Mellitus cate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Hyperlipidemia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Tunknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? 1 ☐ Yes 2 Î No certificate 1 ☐Yes 2 ☐ No Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1∐Yes 2¥ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred .spital or Ath.
'4 hours after death.
'neral Director: Ath.
'led in by the fur-5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 24, 2009 DHILES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Germantown, MD 20874 Vinu Ganti, MD 31. Date filed (Menth, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

24

State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 21, 6:00 A 2009 Nathan Soltoff /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery Manor Care Wheaton 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Days 1 ☑ M 2 ☐ F Yrs. Director 9/1/1917 PA <u> 578-03-1996</u> Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Itame 23a or 28a-f ahor Iner noust be notified at 1 ☑ Yes 2 ☐ No Completed by Funeral Director Silver Spring MDMontgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3330 North Leisure World Blvd. #621 20906 U.S.A.12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r than "natural", or Itan filed within 72 hours after 1 ☐ Yes 2 No 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Meat Wholesale treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file ment of Health and Mental Hy tant: if Itam 27 is marked oth Be 2 Avrum Soltoff Molly Aiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 tam 27 i Rose Soltoff / Wife 3330 North Leisure World Blvd. Silver Spring MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ita any injury or ot ance. 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdn. 7/23/2009 Falls Church VA 22. Name and Address of Facility
Edward Sagel Funeral Direction A Fineral Service Licensee 21. Signature nulla 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostate Cancer **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760. by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2**X** No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Cther: 1 ☐ Yes 2 💢 No 1 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D D52261 July 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1517 Hugo Circle Silver Spring MD 20906 Alan R. Segal MD /32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registra

24 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5PM Charles W. Shock, Sr. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death i Comicc Shu V If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number B Date of Birth Month Day Year 5/21/1952 7. Age (In yrs. last birthday, Months Hours Days 1**X** M 2□ F 57 219-56-3928 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Worcester Berlin 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 11 Duxbury Rd. 21811 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Transit Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Rose Joseph W. Shock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Duxbury Rd., Berlin, MD 21811 Kathy A. SHock / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cape Henlopen Crem. 7/27/2009 Frankford, DE 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home o Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Parti I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock for heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 □Yes 2 □No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ■ No 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Examiner The law requires that the death certificate be executed physician and s the burial-trans Box 68760, attending p signed by the a Ö the ۵. Division of Vital Records, peen To the Hospital or Attending Physician:

Examiner Physician/Medical þ Completed this certificate has ral director, page 2 s Be Certification: To After the

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

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items 23a

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and Mental Hygiene.

Important: If item 27 any injury or other tra

**Physician** 

/Medical

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-003

Director

Funeral

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Completed

Be

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traumatic event, the Medical Examinar must be notified at

/Medical

10a State

9 ☐ Unknown

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified 29505 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5302 CHINABERRY DR. SALISBURY, MD ZISOI GREGORIO M.BELLOSO, MD; 31. Date filed (Month, Day, Year)

State Registrar

BA 15

thours after death.

uneral Director: A
ely filled in by the fu death.

within 24 hours a

Medical

JUL 2

09-05567 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Louis Craig Suttka State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 16, 2009 **Medical Examiner** Louis Craig Suttka, Jr. 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 10651 Gramercy Place, Apartment 257 Columbia Howard 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Funeral Min. Months Davs Hours Director 215-96-5550 40 9/9/1968 1 X<sub>M</sub> Usual Residence of Decedent 10b. County Oc. City, Town or Location 10a. State s 23a or 28a-f show : Columbia Howard hours after death with the Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10651 Gramercy Place Apt. 257 21044 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married 1 X Yes Yes, Give Yea or Dates: Yes 2 X No specify: Widowed Divorced Specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I injury or other traumatic event, the Medical F Baltimore, MD 21215-0036 Police Officer Law Enforcement 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Louis Craig Suttka, Sr. Carol Berger Suttka ۵ 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Craig Suttka, Sr./father 822 SW Munjack Circle, Port St. Lucie, FL 34986 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date Cremation 3 Removal from State crematory or other place) 1 X Burial Sunset Memorial Park 7/20/2009 Berlin, MD Other Specify: Donation 22. Name and Address of Facility Burbage Funeral Home Service Licenses 108 William St., Berlin, MD 21811 Physician re. List only one cause on each line. failu /Medical a. Intraoral Gunshot Wound Immediate Cause (Final disease "xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transi Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth Fetal death 2 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy performed' this certificate 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 1 ✔ Yes 28a. Date of Injury (Month Day,Year) FOUND: 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: FOUND: Subject shot self Natural 1 Yes 2 ✔ No Pending Jul 16, 2009 1225 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1

the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 V No Nursing Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 10651 Gramercy Place, Apartment 257, Columbia, MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie 29c. License number O.C.M.E. July 17, 2009 Name and address of person who completed cause of death (Item 23a) BAY+1 Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State ORIGINAL Registrar OCME 2006 **OCME** 

2009 25330

Time of Death

1226 hrs

MD

10d. Inside City Limits

Yes 2 X No

Country)

white

White, etc.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 23, 2009 7:22 A. Ju1y Μ. Sforza Ernest /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Chesapeake Beach Stream Walk Way If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/28/1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Co*uintry)* Delaware 1 X M 2 □ F Yrs. 87 577-16-5012 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show traumatic event, the Medical Evandran must be notified at 1 ☐ Yes 2 X No Director PA Westmoreland Mount Pleasant 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or U.S.A. 15666 209 Bearfield Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. em 27 Is marked other than "natural", or itei 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify: white ò 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Liquor Stores Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Sforza Cesarina Rinaldi Romeo ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7979 Stream Walk Way, Chesapeake Beach, MD 20732 permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tr. once. Tammy Saunders, granddaughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 M Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Ridge Mem. Park 07/27/2009 Bullskin Township, PA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic small cell lung cancer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown миет тиз certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Section) Large S Hospital: 1 ☐ Yes 2 📆 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 23, 2009 D 33123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.D., 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 Jonathan Lowentha1 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 Physician Pearl Louise Sell 16, 8:45 a M July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Taneytown 4417 Angell Road 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days 1 □ M 2 X F 1930 Maryland 79 215-26-8974 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, in a Medical Examinet must be could as once. 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 □Yes 2 No Taneytown Carroll Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21787 **USA** 4417 Angell Road Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Banking Bank Teller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Percy James Bollinger Pauline Ruth Becker ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4417 Angell Road, Taneytown, MD 21787 Eugene Sell, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/20/2009 Trinity Lutheran Cem Taneytown, MD 22. Name and Address of Facility Myers—Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 21. Signature of Funeral Service Licenses 83a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Houte Re /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) cate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, F FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

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To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	26. Place er: 4 □ Nu
tion: 1	27. Manner of Death  1    1    1   1   1   1   1   1   1	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Worl Injury  M 1	yat k? Yes 2 □

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To the Hospital or Attending Physician: The law requires that the death certifi		To the Funeral Director: After this certificate has been signed by the attending	completely filled in by the funeral director, page 2 should be detached for use as	
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_HTW.		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical	26. Place of Death (	'Check only one)
examiner? 1 ☐ Yes 2 <b>▼</b> No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 Residence 6 □ Other (Specify)
27. Manner of Death 1 ☑ Satural 5 ☐ Pending 2 ☐ Accident investigation	n (Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ff. Location (Street and Number or Rural Route Number, City or Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	
29b. Signature and title of certifier	29c. License number 0.3794.9	29d. Date signed (Month, Day, Year)  July 16 th 2009

23e. Did tobacco use contribute to the cause of death?

3 Probably 4 Unknown

No No

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Registrar

31. Date filed (Month, Day, Year)

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ause of death (tem 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month 2009 3:40a. July 15, Pearl Marvel Sanders 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll Long View Nursing Home Manchester Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 🔽 F Months Days Hours 218-03-3010 87 Dec. 29, 1921 MD. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 Yes 2 No MD Carroll Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21074 3800 Sunnyfield Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 1 \_Yes 2 \_No 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) sewing factory seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Calp Mary Crue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1600 Baust Church Road, Union Bridge, Md. 21791 Bonnie L. Fringer, daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter's Lutheran 7/18/2009 Hampstead, Md. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service License M01072 934 S. Main Street, Hampstead, Md. 21074 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 2 ☐ Fetal death 3 Ectopic pregnancy Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐ No 26. Place of Death (Check only one) Hospital Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural

Physician /Medical Examiner

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To the Hospital of within 24 hours a To the Funeral D Hospital

The law requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

**Physician** 

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**Funeral** 

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

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burial-transit the. as ase for signed by the a page 2 should completely filled in by the funeral director, မ Certification:

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

6 ☐ Could not be

25. Was case referred to medical examiner?

28c. Injury at Work? 1 ☐ Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

2 Accident

3 Suicide

4 - Homicide

and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed pauserof death (Item 23a) (Type, Print)

Honor 31. Date filed (Month, Day,

Year)

P0 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 12:37 P M KATHERINE G. SMITH 7/31/2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 3911 VINCENT RD. **DORCHESTER** LINKWOOD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Hours 1 □ M 2 🕱 F Months Days 8/26/1928 **Director** 218-20-9438 80 MÁRYLAND Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show ? is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Madical Examinar must be not infined at Director 1 ☐ Yes 2 X No MARYLAND DORCHESTER LINKWOOD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3911 VINCENT RD. 21835 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or iten any finury or other traumatic event, Ites Maclical Examina 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **SEAMSTRESS** MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WASHINGTON GORE DAISY HUGHES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACK SMITH /HUSBAND 3911 VINCENT RD., LINKWOOD, MD 21835 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State MID SHORE CREMATION CENTER 8/1/2009 CAMBRIDGE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CURRAN-BROMWELL FUNERAL HOME, P.A., 308 HIGH ST., CAMBRIDGE, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Virease Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): attending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) P.O. I 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2000 2 🗆 No 1 ☐ Yes 1 🗆 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 2 No Hospital Other: Certification: To 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Sesidence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
Accident Injury 5 Pending death. investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

4 hours after death. within 24 hours a To the Funeral L the Hospital

> State Registrar

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) Wildmur 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Dorchester Ave.

29d. Date signed (Month, Day, Year)

2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Of Maryland / D. State Of Maryland / D. State Registrar	Certificate of L			g. No. 2009	25335
	Physicia	an	1. Decedent's Name (First, Middle, Last)			Date of Death     Month	Day ₩ Year	3. Time of Death
	/Medic	cal	Virgilio Vasquez  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	Jun6	25" 200° 4c. County of Deat	
	Examin	ier	Seasons Hospice	Randal	lstown		Baltim	
	Funeral Director		.32 30 3313	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Pay, 1 / 10 / 19	Ye <i>ar</i> ) 9. Birt E1 Co	hplace (State or Foreign untry) Salvador
Maryland	ied at	tor	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town   Winds   10d. City   10d.	or Location Sor Mill				10d. Inside City Limits 1 □Yes 2 No
h with the	23a or 28e st be not	al Direc	10e. Street and Number 3629 Rockdale Terrace	10f. Zip Code 21 2	244	10	g. Citizen of What Co El Salv	
ING Z1Z15-UU36 be filed within 72 hours after death with the Maryland	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe In, Mexican, Puerto F Specify: 1 vadoran		14. Race - Ame Black, White Specify: W	
21215-0036 1 within 72 hours aft	n "natural Ardical E	pleted I	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired			6b. Kind of Business/	
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<b>Saitimore,</b> permit. Pages 1 ar	Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic events.		4 Donation 5 Other (Specify) King	Disposition (Name of crematory or other place Memorial	Pk.7/03/	2009	Windsor	Mill,Md
Deal permit	Depar Impor any In once.		21. Signatur Tyneral Service Lic have	<u>'                                    </u>	mbia Bl	vd.Silv	er Sprin	g,Md20910
/	ysician Medical caminer		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of	rcinoma	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
<b>6876U</b> , tificate be executed	g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause. List of verying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last					
<b>5875U</b> , ificate be ex	physic s the bu	edical	d					
ords, P.O. BOX (requires that the death certi	has been signed by the attending e 2 should be detached for use a	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	у		23d. Date of de Month	livery Day Year
uires that th	n signed by	ρ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	en in Part I.		acco use contribute to	o the cause of death?
§ (C)	cate has bee page 2 shou	Completed				24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
VITAI	s certifi irector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	nationt 3 🗆 DOA Othe	26. Place of Death	n <i>(Check onl_one</i> me 5 ☐ Resider	400	ans Hospice
ION OT	ith. : After this s funeral d	tion: To	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injur	y at 2	28d. Describe how		City)
DIVISION al or Attending	within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office	2	28f. Location (Str. City or Town,	eet and Number or R. State)	ural Route Number,
Hospit	24 hour Funera stely fille	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and manner stated.	death occurred at the tin	me, date and place, opinion, death occurr	and due to the cared at the time, da	use(s) and manner a ite and place, and due	s stated. e to the cause(s)
To the	within:  To the  comple	Mec	29b. Signature and title of certifier	29c, Licens	e number	29	d. Date signed (Mont	th, Day, Year)
	2		relliah & Beutin		5931		July 14th	2009
			30. Name and address of person who completed cause of death (Item 23a) (**  DEBOTAL T BUTTOM 783.	Type, Print) S SMIH Ava	enzue Su	ule 703	Baltimore	MD 21209
	Sta Registr		31. Date filed (Month, Day, Year)  32 Registrar's Signature	hares				

			4 601	partment of Health and Nertificate of Death	Mental Hygie Reg.	0001	25336
ı	Physici	an	1. Decedent's Name (First, Middle, Last)  Annette Gail Hersch Warnock		2. Date of Death Month July 22,		3. Time of Death 12:53 pt/
-	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			Holy Cross Hospital	Silver Spring		Montgo	omery
H	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 △ F 69 17. Age (In yrs. last birthd 69 17. Age (In y	Months Days Hours Min	8. Date of Birth (Month, Day Ye April 16,	ar] 1940 Ca	rthplace (State or Foreign ountry) a Lifornia
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryli -f sho	to		evy Chase			1 ☐ Yes 2 🔼 No
	h the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What C	ountry?
	ath wit		8713 Susanna Lane	20815		USA	
980	thould be filed within 72 hours after death with the Maryland of Mental Hyglene.  marked other than "natural", or items 23a or 28a-f show matic event, it a Medical Evaning must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify:</li> </ol>	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	vithin 72 hor sne. I <b>han "natur</b> e Modica I	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of work p. DO NOT use retired)		. Kind of Business	,
0 2	filed v Hygie other i	ပိ	17. Father's Name (First, Middle, Last)	reacher 18. Mother's Nam	e (First, Middle, Maid	Educatio	on
<u>a</u>	ould be the Mental arked of atic everage.	To Be	Paul Hersch	Adele Gra		1011 0011/41110)	
, Mar)	12s har 7 is trau		19a. Informant's Name/Relationship (Type. Print)  John A. Warnock, III/Husband	ailing Address (Street and Number or Run 8713 Susanna Lan			
altimore,	Pages 1 and ment of Healt ant: If Item 2: ary or other		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)	rematory or other place) Ju	1 77 23	Location - City or Lexandria	Town, State a, Virginia
Balt	permit. Pages Department of Important: If II any Injury or once.		21. Signature of Funeral Service Licensee	22 Name and Address of Facility Francis J. Collins 500 University Blv	Funeral l	Home Inc.	ng,MD 20901
			23a. Part1. anter the disease, or complications that can sed the death. Do not shock, or heart failure. List only one cause on each line.			_	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic (resulting in death)	Cardiovascular Dise	ase		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
	<u> </u>	ner	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying				
0	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c.				
8/60,	icate be ex physician s the burial		Due to (or as a consequence of):				
	tificate ng phy as the	ledical	d				
X ROX	death certific e attending p id for use as	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death	B Ectopic pregnancy		23d. Date of de	
	the dea	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)		Month	Day Year
ς, Γ	that the ned by detac	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
cords	Ine law requires that the diate has been signed by the sage 2 should be detached	ed by			1 □ Yes	2 No 3 P	robably 4 🔀 Unknown
Sec.	2 3 a	Completed			24a. Was an autopsy		utopsy findings available completion of cause of
ָם ק	ding Physician: The in the interpretation of the interpretation of the funeral director, page				performed 1 ☐ Yes 2 ☐	? death? No 1 ☐ Yes	2 No
VITAL	s certif	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 X No Hospital: 1 ☐ Inpatient 2 ☐ XER/Outpat	Other:	h (Check only one)		
0 2	og Pny ter this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 Residence 28d. Describe how in		ecify)
SION	frendir feath. tor: Af the fur	catio	2 Accident investigation	M 1 □Yes 2 □No			
	ital or At its after d al Direct led in by	Certification:	4 Homicide determined 256. Place of Injury - Athome, farm, building, etc. (Specify)		28f. Location (Street City or Town, St	ate)	
	or ne nospina or Attending Priysician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, p	ledical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	con Towith	Σ	29b. Signature and life of confilier	29c. License number D64296		Date signed (Mont 11y 22, 2	
	J		30. Name and address of person who completed cause of death (Item 23a) (Typ Richard Nguyen, MD 1500 Forest GI	en Road, Silver Sp	ring, MD	20910	
	Stat Registra	~	31. Date filed (Month, Day, Year) 32 Registrar's Signature	arked			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 22 10:40 P<sup>M</sup> Ju1<sub>v</sub> 2009 Thomas J. Wilson 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince Georges Cheltenham 10416 Angora Dr. | HUnder 1 Year | HUnder 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 31, 1 9. Birthplace (State or Foreign Country) 1948 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **M**M 2□ F Yrs. 075-40-0170 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2/17 No Maryland | Prince Georges Cheltenham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A 20623 10416 Angora Dr. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Types 2 No1967-If Yes, Give Year or Dates: 1971 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🛣 No Specify. Specify: 3 ☐ Widowed 4 🗓 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Police Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Thomas Wilson Mary Margaret Moran 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Nevada Ave. Odenton, MD 21113 Kerrie Wilson (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 28, 2009 Cheltenham, MD MD Vet's Cemetery 21. Sign three of Funeral Service Licensee MOISSS 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Pa/t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 4 Pregnant at time of death 1 □Yes 2 □ No 9 Unknown 9 Unknown

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Magnobies.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Be

2

Examiner

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

sician and burial-transit

Records, of Vital Division

The law requires that the death certificate be executed cate has been signed by the attending physician page 2 should be detached for use as the buria certificate Hospital or Attending Physician: this hours after death.

neral Director; After this y filled in by the funeral d 24 hours

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Part II. Other significant conditions  AUDHOU	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unkno
25. Was case referred to medical		autopsy prior to completion of cause death?  1 □ Yes 2 ▼No 1 □ Yes 2 □ No
examiner?	Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Ho	th (Check only one)  ome 5 AResidence 6 □ Other (Specify)
27. Manner of Death  1	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M  28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

UNE CECTEN WHOM

State Registrar

29b. Signature and title of certific

Date filed (Month.

Year)

within 2 To the

		-	For State Registrar	State of Maryland		rtment of H tificate of L			giene <sub>Neg. No.</sub> 2009	25338
F	Physicia	ın	Decedent's Name (First, Middle, Last)	COLWELL W	IGGINS	3		2. Date of Dea Month	th Day Year 21 2009	3. Time of Death 11:50 A M
	/Medic Examin		4a. Facility Name (If not institution, give stre	eet and number)		4h. City. Town, or	Location of Death A PARK	JULY	4c. County of De MONTGOMI	
and the same	Funeral		WASHINGTON ADVEN	TIST HOSPITA  7. Age (In yrs. Ia.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		irthplace (State or Foreign
L	Director		578-30-6775	1 2 K F 83	Yrs.	Months Days	Hours Min.	MARCH 1		RTH CAROLINA
	ryland thow		10a. State 10b. County		Town or Loc					10d. Inside City Limits 1 XYes 2 No
	the Ma	Director	MD PRINCE GEO	ORGE'S BR	RENTWO	JD 10f. Zip Code			10g. Citizen of What (	<u> </u>
	th with 23a or ust be	ral Di	4116 40th STREET			20722			USA	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hipportant: If item 27 is marked other than "attra hipportant in a state in a stat	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 1 Year or Dates:		Vas Decedent of Hi f Yes, specify Cuba □ Yes 2√ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		nerican Indian, ite, etc. BLACK
21215-0036	n 72 ho "natur	oleted	15. Decedent's Educati (Specify only highest grade co	ompleted)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during most of work	ing	16b. Kind of Busines	·
212	ed withir /giene. er than t, the M	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		STAL CLEF	KK		GOVERNME	NT 
and	d be file ental Hy ked oth c even	To Be	17. Father's Name (First, Middle, Last) GEORGE WILLIAMS				DAISY	ROSE MC	Maiden Surname) LEAN	
Maryland	2 shoul and M is mar raumati	-	19a. Informant's Name/Relationship (Type.		19b. Mailir	g Address (Street	and Number or Rur	al Route Numbe	er, City or Town, State	, Zip Code) 20020
re, N	s 1 and of Health item 27 other t		LARRY W. COLWELL/ 20a. Method of Disposition	20h Pia	ace of Dispo	sition (Name of	1	Date	20c. Location - City	or Town, State
Baltimore,	t. Page: tment o tant: If tany or		1 ☐ Weurial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from State MD			PERY 7/28		LAUREL, MA	
Ba	permit Depar Impor		T. S., nature   Euneral Service   Ansee			: Name and Addres			ER, MARYLAN	
			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one	cause on each line.						Approximate Interval Between Onset and Death
()	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque		RATOR	24 F	AIL	U RE	
· *	Examiner	J.	Sequentially list conditions, b	CARDIA ( Due to (or as a consequence)		JRRH "	YTHM.	IA		
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	RENAL	F	ALLU	RE			
68760,	eath certificate be executed attending physician and for use as the buriat-transit	al Ex	resulting in death) Last	A N EM I						
( <b>68</b> 7	ertificate ing phy: e as the	Medical	IF FEMALE:			-				
.O. Box	Attending Physician: The law requires that the death certificate be executed riceath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month	delivery Day Year
rds, P.	w requires that the de been signed by the should be detached	Ď	Part II. Other significant conditions contri	buting to death but not resul	ilting in the u	nderlying cause giv	en in Part I.	23e. Did t		e to the cause of death?  Probably 4 ☐ Unknown
l Reco	The law re ate has be bage 2 sho	Completed						24a. Was autor perfo 1 □Yes	osy prior ormed? death	autopsy findings available to completion of cause of ? es 2 \textstyle to
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:	50/0	ot 3 🗆 DOA Oth	26. Place of Dea		<del></del>	
u of	ding Physician: The n. After this certificate h funeral director, page	on: To	1  Yes 2  No	1 24 Inpatient 2   1	28b. Time o Injury	IL 3 LL DOA	4 LI Nursing H		dence 6 Other (5 how injury occurred	респу)
Division of Vital Records,		Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hos building, etc. (Specify			Yes 2 □ No	28f. Location (. City or Tox	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I		(Check only 2 Medical Examine	cian: To the best of my know er: On the basis of examinat	wledge, deat	h occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
1	To the I- within 24 To the F- complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (M	
	1 0		> Chandes elce	/			285	5	7/23	109
	12		30. Name and address of person who com CHANDRASEKHAR KORA	pleted cause of death (Item APATI M.D. 72	23a) (Type, 07 HAI	Print) NDOVER PA	RKWAY #8	GREENBE	LT,MARYLA	ND 20770
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signat	park	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) . Month **Physician** Cynthia Rebecca West DUL 18 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SAI, S byey If Under 1 Year If Under 24 Hrs. Re md w. comico nues. CT Sbuky abx Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 ☐ F 09-29-1940 Florida Director 426-86-9412 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State la or 28a-f show t be notified at 10b. County 1 ☐ Yes 2 No Directo Princess Anne MD Somerset 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r Items 23a o iner must be USA 21853 10611 Perryhawkin Church Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1□Yes 2X No Specify. Specify: ş 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker/medical recordsState of Maryland 12 none permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If Item 27 Is marked other any injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Mae Erwin William Baumgardner ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 19a. Informant's Name/Relationship (Type. Print) 10611 Perryhawkin Church Road, Princess Anne, MD Walter West/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Perryhawkin Christian 7/22/2009 Princess Anne, MD 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 4 MO0295 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 2 year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 100 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 performed? this certificate 1□ Yes 2 40 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 1 ☐ Yes 2 JAK 1 🔲 Inpatient 2 ER/Outpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural s after dea...
ral Director: After 5 Pending 1 🗌 Yes investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 - I ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

(g) State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

200

Ro

Year)

liam

31. Date filed (Month, Day,

		1- For State Registrar		Certif	icate of L	Jeath	_	R	eg. No. 20	09 25
Physicia dical Exami		1. Decedent's Name (First, Middle,Last)  Russell E	dward W	lenze]				2. Date of Dea Month July 25, 2	Day Year	3. Time of Death 0109 hrs
		4a. Facility Name (if not institution, give St. Mary's Hospital ED	street and number)			. City, Town, or L Leonardtown		th	4c. County of Dea	ath
Funeral Director		5. Social Security Number 6. Sex 139-40-9253	7. Age (	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours M	_	7. Tth (MM/DD/YYYY 9. I	Birthplace (State or eign New Jer Country)
nd show any ce.	_	Usual Residence of Decedent  10a. State 10b. County  MD St.	Mary's		wn or Location Timber					10d. Inside City Li
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	10e. Street and Number 44639 Shallow For	d Court			10f. Zip Code 20690			10g. Citizen of What Ci	ountry?
r death with or items 23 must be no	Funeral	11. Marital Status  1 Never Married 2 X Married		ver in U.S.	If Yes	, specify Cuban,	Mexican, Puer	Specify Yes or No to Rican, etc.)	White, etc	
72 hours after death with the Maryland n "natural", or items 23a or 28a-f shr al Examiner must be notified at once	ē.	3 Widowed 4 Divorced 15. Decedent's Education (Specify onle Elementary/Secondary (0-12)	If Yes, Give Year or Dates: y highest grade comp College (1-4 or 5+		Ba. Decedent's	es 2 X No Usual Occupation of working life.	on (Give kind o		Specify:	White ss/Industry
MD 21215-0036 32 should be fited within 77 th and Mental Hygicine. 127 is marked other than umurite event, the Medical	Completed	12. Father's Name (First, Middle, Last)	4	<u> </u>	Sale	s Manage		ne (First, <b>M</b> iddle,	Prir Maiden Surname)	nting
21215 ould be file d Mental H s marked itc event, t	To Be	Arthur Wenzel  19a. Informant's Name/Relationship (Ty	pe, Print)			•	and Number o		mber, City or Town, St	
re, MD s 1 and 2 sh f Health an If item 27 i		Steven B. Wenzel  20a. Method of Disposition  1 Burial 2 X Cremation 3		20b. Pla	ce of Dispositi	agle Room (Name of cerrifor place) Hor	etery.	Woodby	oidge, VA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Higgiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	<del>2</del>	Adan	IS-Gree 22. Na	n Funera me and Address	of Facility	/30/2009	Herr	
M 링크트를 Physician /Medical	- 3	23a. Part I. Enter the disease, or complifailure. List only one cause on each		he death. Do				ral Home		Approximate Int
xaminer			Multiple Injuries	quence of):						Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):								
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30x 68760 death certificate le attending physical for use as the bu	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at ti 9 Unknown	ime of death	5 Othe	er (Specify)			100	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the billed in the funeral director, page 2 should be detached for use as the billed in the funeral director.	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  2 ✓ Accident Investigation  3 Suicide 6 Could not be determined determined?  29a. Certifier 1 Certifying Physicial (Check only one) 2 ✓ Medical Examiner:  29b. Signature and title of certifier	Pregnant at ti 9 Unknown contributing to death  Despital: 1 Inpatien  28a. Date of Injury Jul 25, 2009  28e. Place of Injury (Specify) roac  an: To the best of my On the basis of examand manner stated.	but not result 2  Ely 2  2  2  2  2  2  2  2  2  2  2  2  2	R/Outpatient 8b. Time of In, 10008 hrs i.e., farm, street	26.Place 3 DOA ury 28c. Injur 1 Y, factory, office b	of Death (Checother's Nurry at Work?  es 2 No wilding, etc.  te and place, a death occurre a number	24a. Wai aute perl 1 🗸 Yes ck only one) sing Home 5 28d. Describe Subject dri 28f. Location or Town, Piney Point and due to the call dat the time, dat	es 2 No 3 F s an ppsy prior occurred? 2 No 1 P Residence 6 O e how injury occurred over of vehicle in vehicle	Probably 4 Vunknie autopsy findings avato completion of caus 1? Yes 2 N  ther:  vehicular accider  Rural Route Number d Road, Leonardto  stated. o the cause(s)
Division of Vii To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  2 ✓ Accident Investigation  3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Physicia one) 2 ✓ Medical Examiner:	Pregnant at ti 9 Unknown contributing to death  Despital: Inpatien  28a. Date of Injury Jul 25, 2009  28e. Place of Injury (Specify) roac  an: To the best of my On the basis of exam and manner stated.	but not result to the state of	R/Outpatient 8b. Time of Inj 1008 hrs i.e., farm, street death occurry or investigation 3a) aminer	26.Place 3 DOA ury 28c. Injur 1 Y , factory, office bed at the time, da on, in my opinion 29c. License O.C.I	of Death (Cher) Other; Nur y at Work? Yes 2 No uilding, etc. te and place, a death occurre onumber M.E. OCM	24a. Wai aute perl 1 🗸 Yes ck only one) sing Home 5 28d. Describe Subject dri 28f. Location or Town, Piney Point and due to the call dat the time, dat	es 2 No 3 F s an ppsy portion deat of the post of the	Probably 4 V Unknown autopay findings avaito completion of causito 2 Yes 2 N N N N N N N N N N N N N N N N N N

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Amend I tem 4 per FH 9874 87709 dk
State of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 8:45 PM **Physician** 2009 02 MHITED 08 JOYCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Maryland Medical System Baltimore Baltimore of 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day Jul 31 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months A- 530-32-3630 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Michel Examinar must be notified at Cumberland 1 □ Yes 2 □ No Allegany MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with USA 21502 14806 Viewcrest Road, SW Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 □ **X**o Baltimore, Maryland 21215-0036 Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker es 1 and 2 should be filed w of Health and Mental Hygie fitem 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie (Jolley) Ruesch Hyrum Ruesch ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 Cumberland 14806 Viewcrest Road, Steven Whited husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 8/7/2009 MD Flintstone 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Carpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 

Sersis

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ē Hospital or Attending Physician: The law requires that the death certificate be executed Examin burial-transit Hepatic Failure and Due to (or as a consequence of): P.O. Box 68760 signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 📉 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pagr 2 No 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1477788867 08/02/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 2120 SANDO 22 South Greene St. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 8 per 11 8894 8-11-09 yt the all Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** enry /Medical 4c. County of Death 4a. Facility Name IIf not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1929 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Days 1 XM 2 F 08/10/<del>2009</del> Maryland 79 009-16-5848 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore MD Director must be notified 10g. Citizen of What Country? 10e. Street and Number 830 W. 40th Street 10f. Zip-Code 21211 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Korrean Warr Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify: ģ 3 XWidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Mining/Computer Businessman 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Valle Hagerty Otto Eugene Adams : If item 27 is marke or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5910 Folkstone Road, Bethesda, MD 20817 Elizabeth M. Adams-Swann/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Ardent Cremation Services 08/10/2009 | Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee Laura Cettardesty 7522 Connelley Drive, Ste.N, Hanover, MD 21076 Molly 23a. Part 1. Enter the disease, or complical this that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner O. NO N Cancer if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE: completely filled in by the funeral director, page 2 should be detached for use 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Dav 4 Pregnant at time of death
Unknown in the past 12 months? 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ò 2 No 3 Probably 4 V Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 1 Inpatient မ 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending investigation 2 🗌 No 1 Tes 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of agrifier RES- 500

Registrar
DHMH 17 Rev 1/2001

State

600 North Wolfe St, Baltimore, MD, 21287

STONANGO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AM

AUG 1 0 2009

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death **S**Day 1. Decedent's Name (First, Middle, Last) PM **Physician** 9:05 illiam /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PARKVILLE OAK CREST CARE CENTER Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year ORRES **Funeral** Months Days Hours Min. 1 □ M 2 □ F Yrs. 03/28/1920 215-14-0251 89 CANADA Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County id other than "natural", or items 23a or 28a-f show event, the Madical Eventual in ust be nutified at 1 ☐ Yes 2√☐ No Directo BALTIMORE MD PARKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8810 WALTHER BLVD. APT. 1231 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 72 hours after 1 □ Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th GRADE College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any injury or other traumatic event, I all once. COMMERCIAL REFRIGERATION OWN BUSINESS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARL ALMQUIST EDNA CRAWFORD ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8810 WALTHER BLVD. APT. 1231 PARKVILLE, MD 21234 of Disposition (Name of Date 20c. Location - City or Town, State MARION ALMQUIST/WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/10/2009 METRO CREMATORY INC. CATONSVILLE, MD 22. Name and Address of Facility 21. Signature of Funeral Service M01139 THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part I. Enter the disease, or complications that caused the death shock, or heart failure. List one one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical the as attending for use as IF FEMALE: f yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. the 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ HO 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death After t Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who comple cause of death (Item 23a) (Type, Print) 8800 Walther Blul Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036 Physic /Med Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Date 2 should be a signed by the attending physician and

	State Registrar	Certificate of Death	Reg. No. () () () () () () () ()				
sician	Decedent's Name (First, Middle, Last)  Records		2. Date of Death Month Day Year 12'05A				
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eral tor	ec. L. 1 M 2 D.	n yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  July 21, 1909  9. Birthplace (State or Foreign Cauntry)  Mary and				
45	Usual Residence of Decedent  10a. State 10b. County 10	c. City, Town or Location	10d. Inside City Limits				
ector	Maryland N/A	Battimore	1 Des 2 No				
Funeral Director	1506 Penrace Avc.	10f. Zip Code 21223	10g. Citizen of What Country? USA				
any injury or other traditional event, the model event in the traditional once.  To Be Completed by Funeral Director	11. Marital Status  1 Dever Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces? 1   Yes 2   Married   1   Yes 2   Married   1   Yes 3   Married   1   Yes 3   Married   1   Yes 4   Yes 7   Married   1   Yes 6   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 8   Yes 7   Married   1   Yes 9   Yes 7   Yes 9   Yes 7   Yes 9	in U.S. 13. Was Decedent of Hispanic Origin? (SpifYes, specify Cuban Mexican, Puerto 1 \( \subseteq Yes \) 2 \( \subseteq No \) Specify:	pecify Yes or No- Prican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Dack				
led I	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business/Industry				
Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)  HOUSEKEEPER	Private				
Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)				
To E	Arthur Brown	Marie	McCain				
Hacing	19a. Informant's Name/Relationship (Type. Print) Marte McCain - mother	19b. Mailing Address (Street and Number or Run 1500 Pennse Ave.	ral Route Number, City or Town, State, Zip Code) 21223 Battimar, Maryland				
	7	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State				
<u>,</u>	4 Donation 5 Other (Specify)	Woodlawa Cemetery 8/1.	3/09 Woodlawn Maryland				
OUCE.	21. Signature of Funeral/Service Licensee	22. Name and Address of Facility Fav 3512 Frederick	Ker Funeral Home P.A. 21229 Ave. Raltimere Maniford				
Examiner Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)						
/Medical Exar	that initiated events resulting in death) Last C. Due to (or as a co						
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of part in the past 12 months? 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year				
by Pł	Part II. Other significant conditions contributing to death but no	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown					
eted	1						
Completed			24a. Was an autopsy performed?  1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No				
Be (	25. Was case referred to medical examiner?		th (Check only one)				
ပ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient		ome 5 Residence 6 Other (Specify)				
tion	27. Manner of Death  1 Natural 5 Pending (Month, Day, Ye		28d. Describe how injury occurred				
Certification:	2 Accident investigation 3 Suicide 4 Homicide   M   1 Yes 2 No   28f. Location (Street and Number or Rural Rot City or Town, State)   28f. Location (Street and Number or Rural Rot City or Town, State)						
Medical Certification: To Be Completed by Physician/Medical Examir	(Check only 2 Medical Examiner: On the basis of ex	ny knowledge, death occurred at the time, date and place, amination and/or investigation, in my opinion, death occur	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)				
Med	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)				
	Mangell &	3 UIN STUDI	8110109				
	30. Name and address of person who completed cause of deat	(flem 23a) (Type, Print)	14 11/ 00/ 2011/2122				
	WILLS & MUEJIRH	VV A 4/8 Command and to 100					

		4	State of N	•	epartment of H Certificate of L			2% e% ex	25 250 as 1 awa
			1. Decedent's Name (First, Middle, Last)		vertificate of t	Jean	2. Date of Dea		3. Time of Death
	Physicia	ın	Lloyd Gilbert	Brin	nn		Month Aug. 3,	Day Year 2009	6:15 A <sup>M</sup>
-	/Medic Examin		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or	Location of Death	,	4c. County of Deat	h
>	LXdiiiii		Lorien Mays Chapel		Timonium	1		Baltimor	
	Funeral			Age (In yrs. last birtho	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) Co	hplace (State or Foreign untry)
	Director		240-36-2959	81 Yrs	S		Sept. 1	1, 1927 No	rth Carolina
	w w	-	Usual Residence of Decedent  10a, State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
	f sho	5	Maryland Baltimore	Timon	ium				1 □Yes 2X No
	the 28a-	rec	10e. Street and Number		10f. Zip Code		-	log. Citizen of What Co	untry?
	3a oi		12230 Roundwood Road		21093			U.S.A.	
	deatl	Funeral Director	11. Marital Status 12. Was Decede Armed Force	ent Ever in U.S.	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
٥	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther than Medical Examiner must be notified at ent, the Medical Examiner.	F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ If Yes, Give	₩ No	1 ☐ Yes 2 🔀 No	Specify:		Specify	h + + -
2-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Date	s:	ecedent's Usual Occup	ation		16b. Kind of Business/	hite
7	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)		Give kind of work done of the contract of the	during most of work d)	ing	Tob. Tima of Daomicous	
7	within ene. than the M	E C	Elementary/Secondary (0-12) College (1-40	or 5+)	lroad Mecha			Railroa	d
ס		Be C	17. Father's Name (First, Middle, Last)					Maiden Surname)	
/land	lid be 1 lental   rked o	10 B	Cleophus Brinn			Bessie H	odges Bi	inn	
Mary	2 should be and Mental is marked ( raumatic ev		19a. Informant's Name/Relationship (Type. Print)	- 10				er, City or Town, State, 2	
	and 2 ealth n 27 i		Mary Louise Hacks Brinn (	11111	06 Hesperus		Columbia	20c. Location - City or	
ore	Pages 1 nent of H int: If iter iny or oth		20a. Method of Disposition  1  ☐ Burjat 2  ☐ Cremation 3  ☐ Removal from Sta	. cemetery,	Disposition (Name of crematory or other places Creek,	ce)		,	
aitimore,	E Pag tment tant:		4 □ Donation	Baptis	t_Church_		/2009	Nathalie	, VA
g	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked any Injury or other traumatic er once.		21. Signature of Furleral Service Licens		22. Name and Addre Powe 11 Fur 1603 Willbo	neral Hom	e South I	Boston, VA	24592
	7511		23a. Part1. Enter the disease, or complications that cau	sed the death. Do no					Approximate Interval Between
	Physician	85 (	shock, or heart failure. List only one cause on eac Immediate Cause (Final	olication	25 of 7	PHLMON	ARY E	MKOLISM	Onset and Death  Mon HUS
/Medical disease or condition resulting in death)  Jue to (or as a consequence of the content of					):			MBOLISM	10
	Examiner	INTRACEREBO				EMORR	HAGE		months
	p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of	):				
	ecute and I-tran	хап	that initiated events c	as a consequence of	):				
8760,	ficate be executed physician and sthe burial-transit	alE							
687	ficate phys	edical	d.						
X	leath certific attending p I for use as	sician/Me		ome pf pregnancy	O Catania avagacan	.,		23d. Date of de	•
. Box	death e atte d for	icia	in the past 12 months?	th 2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		Month	Day Year
<u>Р</u>	at the by the tache	Phys	9 Li Unknown				00 5/1		- the saves of dooth?
Vital Records, F	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	by	Part II. Other significant conditions contributing to deal	th but not resulting in t	the underlying cause giv	ven in Part I.		obacco use contribute t Yes 2□No 3□F	robably 4 Denknown
Sor	w require been sign	Completed					24a. Was	an 24b. Were a	utopsy findings available
Æ	he lav e has	dmo						rmed? death?	
ā	sician: Th certificate rector, pag		25. Was case referred to medical			26. Place of Dea	1□ Yes ath Check onl		2010
>	ysician: The is certificate hadirector, page	To Be	examiner? 1 Yes 2 No Hospital: 1 Inp	patient 2 ER/Outp	patient 3 DOA Oth	ner: 4 Nursing H	lome 5 Resi	dence 6 □Other (Sp.	ecify)
٥	ding Phys 1. After this funeral di		27. Manner of Death 28a. Date of (Month,		me of 28c. Inju	ry at rk?	28d. Describe	how injury occurred	
<u></u>	endir eath. or: Al	ätic	2 Accident Investigation			Yes 2□No			15 11
Division or	or Att	Certification:	determined 200. Flace 0	f inju <b>ry</b> - At home, farr g, etc. <i>(Specify)</i>	n, street, factory, office		28f. Location ( City or To	Street and Number or F wn, State)	Rural Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, to		29a. Certifier (Check only 2 Medical Examiner: On the base)	est of my knowledge,	death occurred at the t	ime, date and place	e, and due to the	cause(s) and manner a	as stated. ue to the cause(s)
	the H hin 24 the Fi	Medical	one) and manne	er stated.	29c Licen	se number		29d Date signed (Mor	oth Day Year)
	To viti	2	29b. Signature and title of certifier		7)	61721		8/3/20	009
	1		77	of dooth // 00-1	Tuno Brict	41121		0/1/20	7001
	HV		30. Name and address of person who completed cause	of death (Item 23a) (I	N. CHAR	CES ST.	STE 4	8/3/20 105, BAL	TO MD
	St	ate		gistrar's Signature			//	1-0/	
	Regist		4110 4 0 0000	1	had.				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 9:33 Rnice 0 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Southern Maryland Georg Hospito Birthplace (State or Foreign Country) | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 17, 5. Social Security Number **Funeral** Months 78 Davs North Carolina 1 □ M 2 🖾 F 237-36-8379 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show or than "natural", or items 23a or 28a-f show 1 XYes 2 No MD Director Prince George's Ft. Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 USA 10502 Cedarwood Lane Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No If Yes, Give Year or Dates: Specify. Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than ' College (1-4or 5+) Custodian Public Schools permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other ti any injury or other traumatic event, I'n once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine (Unknown) John L. Barber ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20744 Ft. Washington, MD 10502 Cedarwood Lane Anthony Hazel - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buria 2 □ Cremation 3 □ Removal from State Carolina Biblical Grdps8/6/09 Jamestown. NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility S.E. Thomas Funeral Service, Inc. 110 Highland Avenue Thomasville, NC 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 500515 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Bilateral Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det Division of Vital Records, 2 4 Unknown Atrial Fibrillation Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? Rate with ventrialar 24a. Was an autopsy performed 1 ☐ Yes 🗡 ☐ No 25. Was case referred to medical examiner? certificate 1 ☐Yes No director, Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this in by the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) and manner stated. the

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tellag Nicholson brown AUG Year) State 10

29b. Signature and title of certifier

29c. License number

1203

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09

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Clinton MO 20736 SURRAMIS

Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:05AM 2004 George James Bitter August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Seasons Hospice-Northwest Hospital Randallstown Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Funeral Year) Months Davs Hours Min. 1**X**□ M 2□ F Maryland Director 13, 62 April 1947 212-44-2563 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Director Dundalk 1 ☐ Yes 2 ☐ Xio Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 United States 1920 Barry Road Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2XXXIo þ If Yes, Give Year or Dates: Specify: Specify: White 3 ☐ Widowed 4XXDivorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natum any Injury or other traumatic event, I'm Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technology 12 years Computer Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ం George William Bitter Dorothy Julia Stachowska 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara J. Cox (Sister) HC 71 Box 34 Augusta, West Virginia 26704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Mary Cem. 8/6/2009 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. P. t1. Enter the disease a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** STAGE IV RENAL CELL CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Metastatic Liver bene: line and 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 2 🗐 No 1 □ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other Repetity No 1705 PCC 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Augustz 2009

Registrar DHMH 17 Rev 1/2001

State

X

28*35* 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Burton

Registrar's Signature

Deberan

31. Date filed (Month, Day, Year)

1445931

Smith Avenue Baltimore MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 2 State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mont Physician Brown 1332 PM Lee ichard 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** of Maryland Medical CTr. Ballimore University Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 **3**M 2 □ F Months Days Hours Director 63 214-44-2282 9, 1945 Maryland Nov. Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits show 10c. City. Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Event Lant he modified at 1 XYes 2 No Director Maryland Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 U.S.A. 681 Tram Way Funeral death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 21 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify. ₽ S Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 delivery truck driver petroleum service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Winford Brown Louise Elizabeth Akers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health a Virginia E. Brown/ wife 681 Tram Way Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/10/2009 | nr. Linwood, MD Pipe Creek Cemetery 22. Name and Address of Facility Hartzler Funeral Home 21. Signature Funeral Service Licen Parine 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 6-105a1 anoxic brain injury resulting in death) /Medical Due to (or as a consequence of): Examiner Multiple Injuries relac arrest REPURENTAN IN PROPERT OF WELFALL ELIMINES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine motor Vehicle and Due to (or as a consequence of) #28b  $tor \pm 1$  Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 ☐ Yes 2 XNo 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 3:20 а.м 5 Pending 1 ☐ Yes 2 X No investigation 8-3-2009 2 Accident Motor Vehicle Crash within 24 hours after death To the Funeral Director: pletely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) RT140 + Gorsuch RL 4 Homicide STreeT Hospitai WESTMINSTER MD Medical 29a. Certifier 1 🗷 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12150747 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roy 22 13011 Ballimore MD ST Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Donald J. Citro,		State of Maryland / Department of Health and Mental Hygiene  1-For State Registrar  Certificate of Death Reg. No. 2009 2534
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  North  Deposite City TTT TT  Month  Day  Year  4900 by 1
(		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
Funeral		Bon Secours Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign
Director		5. Social Security Number 1 Number 35 Yrs. Social Security Number 35 Yrs. Is Under 24Hrs. Social Security Number 35 Yrs. If Under 14Hrs. Social Security Number 35 Yrs. If Under 24Hrs. Social Security Number 35 Number
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
ryland	ģ	MD Baltimore 1 Name 1 Name 1 Name 1 Name 2 No 10g. Citizen of What Country?
Baltimore, MD 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If filen 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	6226 Allumore Way 21224 U.S.A.
ath with	uneral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
after de al", or i	by Fu	1 Yes 2 No 3 Widowed 4 Divorced of Pess. Give Year In Yes. 6 No Specify: Specify: White
hours "natur	ted t	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
5-0036 fled within 7' Hygiene. I other than	Completed	8 Painter Painting
215-0 e filed v al Hygi ced othe	Be Co	17. Father's Name (First, Middle, Last)  Donald Citro  18. Mother's Name (First, Middle, Maiden Surname)  Rose Hash
2121: hould be fill nd Mental F is marked		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, MD and 2 sho lealth and item 27 is	1	Rose Akram/Mother 6226 Allumore Way, Baltimore, MD 21224  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burlal 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Cremation Services 08/10/2009 Hanover, Maryland
Balti bermit. Departm mports njury o	ı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval
/Medical xaminer		failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic (heroin) intoxication  Between Onset and Death
1	П	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.
	iner	if any, leading to immediate Due to (or as a consequence of):
red	Examiner	events resulting in death) Last Due to (or as a consequence of):
50, te be executed nysician and burial - transit	Medical	XUNPENDED #1, 23a,27, PII, 28a-f,perME, g894 8/14/09 TT
8760, ificate be ig physici	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 6876. c death certificate the attending phy	sician/N	past 12 months?  4 Pregnant at time of death 5 Other (Specify)
O. B. at the de I by the tached f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
Records, P.O. B The law requires that the d icate has been signed by the page 2 should be detached	ed by	
cord law req has bee	Completed	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed?
tal Recinant The certificate	e Cor	25. Was case referred to medical 26.Place of Death (Check only one)
Vital hysician:	To Be	examiner? 1 Ves 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA  Other 1 Nursing Home 5 Residence 6 Other:
on of ording Plath.		27. Manner of Death  28a. Date of Injury (Month, Day/Year)  Natural 5 Pending  28b. Time of Injury 28c. Injury at Work?  1 Yes 2X No unk
Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the hours after death. Funeral Director: After this certificate has been signed by tely filled in by the funeral director, page 2 should be detaa	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, City or Town, State) 3 1 5 Small Wood St
Hospi 24 hou Puner tely fil		4 Homicide determined (Specify)  29a. Certifier (Check only one)  29b. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the within 7 To the Comple	Medical	and manner stated.  29b_Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
		(all 1 1 1 1 O.C.M.E. August 3, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	w	31. Date filed (Month, Day, Year)  32. Registrar's Signature
Regist		AUG 10 2009 Lever S. OFFIGINAL DEME
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December Name (PSM Adda, Lass)   December 19		1.	For State Registrar	State of Maryland		artment of F rtificate of I			iene eg. No. O O O O	0000
Table of the control				)				2. Date of Deat	<u> </u>	3. Time of Death
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190. Base   190. County   190.	Director Director	4	132 10 10 10	M 2□F 86		Months Days	Hours Min.	oct.18,	1922 Les	econ, Missou
23a Part   Effect the desase of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate shock of heaft failure, light only one cause of each line.	wo #	10								10d. Inside City Limit
23a Part   Effect the desase of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate shock of heaft failure, light only one cause of each line.	natural", or items 23a or 28a-f show dieal Ever it wit must be notified at effect by Funeral Director		-4	re County T	imoniu				0.000	
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22a. Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Was accordent pregnant in the past 12 months of a large of the past 1	the Me	d L	Elementary/Secondary (0-12)	College (1-4or 5+)					West	inghouse
22a. Part I. Effer the disease of complications plag caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mode and plag	vent,	ဖူ   17								
23a. Part   Febre the disease of complications fluid caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Approximate shock of health failure, light only one cause of light one cause of light one c	arked atic e	o 1								
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22a. Part J. Effer the disease of complications flat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate shock or heaf failure. Light only one cause of each line.  The mediate Cause (Final failure)  Sequentially list conditions, cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Due to for as a consequence of):  Due to for a	int: If Ite	20	1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State			, 1100	.11,		
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Immediate Cause (Final death)   Due to (or as a consequence of):		2	3a. Part 1. Enter the disease or comp	lications that caused the death	<u>-</u>					Approximate Interval Between
Sequentially list conditions, and a consequence off:    The part of the part o		lr d	mmediate Cause (Final isease or condition	a Kidne	4					i e
Sequentially list conditions  Due to [or as a consequence of]:  Due to [or	_	re	esulting in death)	Due to or as a consequ	uen le of):					100 -5
Due to (or as a consequence of):    FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   5   Other (specify)   Month   Day   Year   1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to completion of cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to completion of cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to completion of cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to completion of cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete on cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete on cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete on cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete on cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete on cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete on cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete on cause generations   1   Yes   2   No   3   Probably   4   Other   4   Normaling and prior to complete generations   4   Normaling and prior to complete generations   4   Normaling and prior to complete		S	equentially list conditions,	b. Due to for as a conse	ience of:	>				Tear >
FEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. D	ansit min	E C	ause. Enter Underlying tause (Disease or injury		1200					
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	an an rial-tra	ລິ∣"	esulting in death) Last	Due to (or as a consequ	uence of):					
FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1	the bu	dicai		d						
Section   Part     Other significant conditions contributing to death but not resulting in the underlying cause given in Part     23e. Did tobacco use contribute to the cause of death   1   Yes   2   No   3   Probably   40   Unknown	D 86   G								23d. Date of d	elivery
1   Yes   2   No   3   Probably   4   Unknown of the completion of cause of the cause of the completion of cause of the cause o	d for u		in the past 12 months?	4 ☐ Pregnant at time of c			;у 		Month	Day Year
1   Yes   2   No   3   Probably   40   Unkn	by the	lys _		9 ☐ Unknown						
24a. Was an autopsy findings available of completion of cause death?  25. Was case referred to medical examiner?  1   Yes   2   2   2   2   2   2   2   2   2	gue d		art II. Other significant conditions co	ontributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.			0.0
autopsy performed? performed. per	bluod								1	
25. Was case referred to medical examiner?  1   Yes   2   2   2   2   2   2   2   2   2	has e 2	_						autop: perfor	sy prior t med2 death	o completion of cause
1   Yes   2   2   No   1   Inpatient   2   ER/Outpatient   3   DOA   4   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   No   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   Nursing Home   5   Residence   6   Quiter (Specify)   1   Yes   2   Nursing Home   1   Yes   2	ficate		5 146					1 □ Yes	2 (XXX/o   1 □ Yo	es 2 No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fig. Bush mb 6701 N. Charles St. Suit 4105, Rolfimore, MD 2	irecto	m	examiner?	Hospital:	ER/Outpatie	ent 3 DOA Oth				pecify) Hosp
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fig. Bush mb 6701 N. Charles St. Suik 4105, Rolfimore, MD 2	er this	<u> </u>	7. Manner of Death	28a. Date of Injury	28b. Time of	of 28c, Inju	rv at			103
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fig. Buck MD 6701 N. Charles St. Suit 4105, Rolfimore, MD 2	ne fun	atio	2 Accident investigation			M 1□				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fig. Bush MD 6701 N. Charles St. Suit 4105, Rolfimore, MD 2	Jin by th	ertitio	- determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fig. Buck MD 6701 N. Charles St. Suik 4105, Rolfimore, MD 2	Funeral letely filled		(Check only 2 Medical Exam	iner: On the basis of examina	wledge, dea	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Fig Bush in 6701 N. Charles St. Suit 4105, Rolfimore, MD 2	Fo the	2	9b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	nth, Day, Year)
V Frie Buch MD 6701 N. Charles St Suite 4105, Rolfimore, MD 2			Deep Fre	el mis		06	2104		8/7/2	009
V Enic Bush MD 6701N. Charles St. Suite 4105, Kaltimore, MD &		3	0. Name and address of person who	completed cause of death (Iter	n 23a) (Type				10	1 2
	. 1		Enic Buch Mi 1. Date filed (Month, Day, Year)	56701 N.Ch	arke	3 St, S.	4it 410	5, Ka	Himore	MD di

			4 Por	Certificate of Death	, 0	.No.2009 25351
-	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	Timothy Joseph Codd  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 6	, 2009 6:10 P M
	Examir	ier	Gilchrist Hospice	Towson	'	Baltimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
	Director		218-46-4453	/rs.	Jan. 28,	1949 Maryland
	yland Iow		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	e Mar la-f sh	ctor	Maryland Baltimore Baltimo	re		1 ☐ Yes 2 🛣 No
	vith the	Funeral Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	eath v	eral	37 Dunvegan Road  11. Marital Status 12. Was Decedent Ever in U.S.	21228	necify Yes or No-	USA  14. Race - American Indian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinat must be notified at	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 本No Specify:	o Rican, etc.)	Black, White, etc. Specify: White
5-0	72 ho 'natur	eted	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	king 161	b. Kind of Business/Industry
121	within ene. than "	Completed	Elementary/Secondary (0-12)  College (1-4or 5+) 5+	life. DO NOT use retired)  Attorney		Insurance
d 2		BeC	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	
/lan	should be filed vand Mental Hygies marked other tumatic event, In	10 B	Joseph John Codd	Norma D.	Monaghan	
Maryland	de la la la la la la la la la la la la la		19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street and Number or Ru	ral Route Number, C	ity or Town, State, Zip Code)
	1 and Health em 27 ither t			075 Montgomery Road;		, Maryland 21075
ğ	ages ent of it: If it y or o		1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Disposition ( <i>Name of</i> y, crematory or other place) thedral Cemetery 8/1		•
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai		21. Signature of 5 neral Service Livence	22. Name and Address of Facility Ste Funeral Home of Cat	4	
ä	permi Depa Impo any Ir		I Chapell TIA	11630 Edmondson Aven	ue: Caton	sville, MD 21228
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest	Approximate Interval Between Onset and Death
å	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- cun cancer	C, NON-8	NAUCEU MONTHS
	Examiner		Due to (or as a consequence of	ή: Ο		ACTION TO SECURE A STANDARD TO SECURE
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	i):		
p	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events c.			
· 09	be ex ician a burial-		resulting in death) Last Due to (or as a consequence of	ħ:		
68760,	ficate physis the	edical	d.			
Box (			IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	• □ = · · · · · · · · · · · · · · · · · ·		23d. Date of delivery
	e deat he atte ed for	sicia	in the past 12 months?  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
P.0	Attending Physician: The law requires that the death ce roters the After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	Completed by Physician/N	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobac	cco use contribute to the cause of death?
ds,	uires t signe Id be (	d by	ATRIAL FIBRILLATION	and and onlying deaded grown in the con-	1 <b>火</b> ŽÎYes	2 No 3 Probably 4 Unknown
20	law requires as been sign 2 should be	lete			24a. Was an	24b. Were autopsy findings available
æ	The la	E O			autopsy performed 1 □ Yes 2 0	prior to completion of cause of data death?  ¶No 1 □ Yes 2 □ No
Division of Vital Records,	i <b>lcian:</b> Th certificate ector, pag	Be C	25. Was case referred to medical examiner?		th (Check only one)	
of	ding Physician: n. After this certific funeral director,			patient 3 DOA Other: 4 Nursing H	ome 5 Residence	
on	nding F th. : After e funera	tion		ijury Work?  M 1 □Yes 2 □No	26d. Describe now	injury occurred
V:S	r Atter er dea rector by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number,
Ö	ital or Ins aft ral Dii lled in					
. D	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge and manner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occu	rred at the time, date	and place, and due to the cause(s)
10	viii Son	2	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
T			30. Name and address of person who completed cause of death (Item 23a) (	1/04395	H	ugusi 1,2009
			30. Name and address of person who completed cause of death (Item 23a) (IDAN/ILUE DECERMAN, MD 670/ N	ORTH CHARLES STIE	SUITE 410	5 BALTIMORE NO 21204

State Registrar

AUG 1 0 2009

			State of Maryland / Dep	artment of Health and N artificate of Death		ene g. No. O A A A	
			Registrar  1. Decedent's Name (First, Middle, Last)	Tanoato or Dout.	2. Date of Death		3. Time of Death
	Physicia		Ruth Ann Culbertson		Month August 6	Day Year	8:25 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1 0 0 0 0 0 0
	Examin	E1	Summerville at Potomac	Potomac		Montgomery	7
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day,		place (State or Foreign
	Director		201-24-7299 1□M 2配 F 79 Yrs.	Months Days Hours Min.	July 16,	1930 Penns	sylvania
	pu ,		Usual Residence of Decedent				Od Ingide City Limits
	show	-	10a. State 10b. County 10c. City, Town or L	ocation		[	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	Directo	Maryland Montgomery Potomac				
	ith th	Ë	10e. Street and Number	10f. Zip Code		g. Citizen of What Coul	
	s 23a	eral	11215 Seven Locks Road, Apt. #205	20854		nited State	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinational be redified at	Funeral	Armed Forces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecity yes or No- o Rican, etc.)	14. Race - Ameri Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Whit	-6
Õ	tura		15. Decedent's Education 16a. Dec	edent's Usual Occupation		6b. Kind of Business/In	
15	in 72 n "na n Suin	plet	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	king		·
212	with jiene r tha	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 Home	maker		Own Home	
g	othe othe /ent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, M	laiden Surname)	
Maryland 21215-0036	ald be Aenta rked ric ev	To B	Paul Harding	Ruth Sm:	ith		
ary	shou and N s ma uma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number or Ru	ıral Route Number,	City or Town, State, Zij	Code)
Ξ	alth a		Mark E. Culbertson / Son 1412	4 Saddle River Dr	., N. Pot	omac, Mary	Land 20878
altimore,	of He of He item		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of Annatory or other place)	Date 1st 8,	Oc. Location - City or To	own, State
Ĕ	Page ment ant: If		I Buriai 2 LA Cremation 3 Li Hemovai from State	Crematorium, Inc. 200		ethesda, Ma	ryland
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examination and Lear contect and once.		21. Signature of Funeral Service Licegson M00896	2. Name and Address of Facility Obert A. Pumphrey OO W. Montgomery A	Funeral	Home/Rockvi	lle, Inc.
		_	23a. Part 1. Enter the disease, or complications that caused the death. Do not en				Approximate
			shock, or heartfailure. List only one cause on each line.				Interval Between Onset and Death
100	Physician /Medical		disease or condition a. Amyotrophic Lat	eral Sclerosis			2 Years
-	Examiner		Due to (or as a consequence of):				
		er					
	d ansit	Examine	Sequentially list conditions, if any, leading to immediate eaus Enter Undurying Cause (Disease or injury that initiated events				
o,	an ar rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	icate be executed physician and the burial-transit	dical	d				
9	ng ph	Med	IF FEMALE:				
Box	death certif e attending od for use as	an/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	☐ Ectopic pregnancy		23d. Date of delive	rery Day Year
O.	e dez the at	sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Worth	Day real
<u>ď.</u>	d by etach	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying equal given in Part 1	23e Did toh	acco use contribute to	he cause of death?
Division of Vital Records,	The law requires that the death certifithe has been signed by the attending age 2 should be detached for use as	þ	Hypertension	underlying cause given in Fart i.		s 2 □ No 3 □ Pro	
0	requ	Completed					
ě	e 2 s	nple.			24a. Was ar autops	/ prior to co	opsy findings available ompletion of cause of
<u>=</u>		S			perform 1 □ Yes 2		2 □No
<u> </u>	sician: The law certificate has k irector, page 2 sl	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othori	ath (Check only one	ASS	isted
0	> 0 T	<u>۲</u>	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time	ant 3 DOA 4 Nursing H		nce 6 AOther (Spec	fy) Living
ם	ffe ffe	ion	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe ho	w injury occurred	
<u>s</u>	deat ctor; y the	fical	C C Could and be		28f. Location (Str	reet and Number or Rui	al Route Number
2	tal or Attendii rs after death. al Director; A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town	, State)	
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical	29a. Certifier  1 Certifying Physician: To the best of my knowledge, dea  (Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	Day, Year)
			Duston	D28656		August 7, 2	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type				
			Ravi Passi, M.D. 15225 Shady Grove	Road, #208, Rockvi	ille, Mar	yland 20850	)
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and de			

DHMH 17 Rev 1/2001

ORIGINAL

09-06039 James Evans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Evans	State State	e of Maryland / Departme <i>Certifica</i>	ent of Health and Mental ate of Death	Hygiene Reg. I	No. 201	10 2535
Physician/				2. Date of Death Month Da August 2, 20	av Year	3. Time of Death 2310 hrs
/ledical Examine	4a. Facility Name (if not institution, g		4b. City, Town, or Location of De		4c. County of Death	14
	1936 W. North Avenue  5. Social Security Number 6.	Sex 7. Age (In yrs. last birth	Baltimore  If Under 1 Year   If Under 24	Hrs. 8. Date of Birth (	MM/DD/YYYY) 9. Biri	thplace (State or
Funeral Director	214-62-9420 1	M 2 F 57	,,	Min. Nov. 17,	1954 Foreig	untry) Mayland
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o				10d. Inside City Limits
8	Maryland N	IA L	Battimore		Citizen of What Cou	1 Yes 2 No
	10e. Street and Number	th Ave.	10f. Zip Code 21217	109.	USA	indy:
r death with the or items 23a must be noti	11. Marital Status  1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	( Specify Yes or No- erto Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
s after der ral", or i niner mu bv Fu	3 Widowed 4 Divorc	1 Yes 2 No ed If Yes, Give Yeer or Dates:	1 Yes 2 No specify:	· ·	Specify: Bla	ck
2 hours after "natural", I Examiner efed by		only highest grade completed) 16a. I	Decedent's Usual Occupation (Give kind during most of working life, DO NOT use		6b. Kind of Business/ Private	
5-0036 led within 72 hour Hygiene. other than "natt the M diral Exal	17. Father's Name (First, Middle, La	et)	Laborer 18 Mother's N	lame (First, Middle, Mai	,	
21, be fill be	George Evar	5'		lame (First, Middle, Mai		71.0.13
MD 21 d 2 should lth and Me n 27 is ma numatic ev	I week	(Type, Print) 196	o. Mailing Address (Street and Number	r or Rural Route Number		Maryland
s I and Hea	20a. Method of Disposition  1 Burial 2 Cremation		of Disposition (Name of cemetery, ory or other place)	Date 2	Catensville	
.들 ~ 을 돌 ㅎ l	4 Donation 5 Other Special Service Lice		22. Name and Address of Facility	8/8/09 aker FU	resul Ho	re f. A 21229
	Kern	Harlumplications that caused the death. Do no	3572 Frederick	liac or respiratory arres	t, shock, or heart	Yamlar A
Physician /Medical	failure. List only one cause on	each line.  a. <u>Heroin intoxicat</u>				etween Onset and Death
aminer	or condition resulting in death)	Due to (or as a consequence of):				
jner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):				
ted 1 1 1 msit	(Disease or injury that injuded events resulting in death) Last	Due to (or as a consequence of):				
50, te be executed yysician and burial - transit	X UNPENDED	AMENDED 23a,PII,27	,28a-1,perME, g894	8/1/109 T		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transicial Certification: To Bo Completed by Directician/Medical Expedition	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3 Ectopic p	regnancy	23d. Date of delive	Day Year
). Box 6876 the death certificat by the attending phy ched for use as the	1 Yes 2 No 9 Unkno		5 Other (Specify)			
that the ned by the detached		ns contributing to death but not resulting	g in the underlying cause given in Part			o the cause of death?
Division of Vital Records, P.O. later death an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Cocaine use			24a. Was ar autops	1	autopsy findings available completion of cause of
Reco				perform 1 <b>✓</b> Yes 2		
lital Bician:	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/O	26.Place of Death (C Outpatient 3 DOA Other		Residence 6 🗸 Oth	er: Scene
n of V ling Phy After th funeral of	27 Manner of Death	(Month, Day,Year)	Time of Injury 28c. Injury at Work?	_	ow injury occurred	
Division o spital or Attending nours after death neral Director: Aft filled in by the fune	Natural 5 Pendir 2 Accident Investi 3 Suicide 6 X Could	gation 28e. Place of Injury - At home, f	T1:00 pm farm, street, factory, office building, etc.		treet and Number or F	Rural Route Number, City  North Ave
Div Ospital o hours aff meral D		ined (Specify)	residence	Baltimo	re. MD	
o the Ho on the Fu	29b. Signature and title of certifier  29c. Certifying Phy one) 2 Medical Exam 29b. Signature and title of certifier	sician: To the best of my knowledge, de iner:On the basis of examination and/or and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occu	urred at the time, date a	ind place, and due to	the cause(s)
O F H 3 H 3	29b. Signature and title of certifier	Mo	29c. License number O.C.M.E.		29d. Date signed (MA) August 3, 2009	
		tho completed cause of death (Item 23a)				
		t Medical Examiner 111 Per	nn Street, Baltimore, MD 2120	11		,
Stat Registra	1110 4 6	2009 Person	Sparked			

		1	For Ames	nd Item	ns 25 tate	c <sup>of</sup> Me	ryland	, g 8949 Cei	tifica	1 <b>6/65</b> te of l	<b>cal</b> th Death	and M		giene Reg. No.		009	253	5
			1. Decedent's Name	(First, Middle	, Last)		42						2. Date of De	ath Dav	/-	Year	3. Time of Dea	
	Physicia /Medic	al	Allen Tho										+		30	09	00 15	M
AND Y	Examin		4a. Facility Name (If								Location					of Death more		
mar ji					al of B			at hirthday		timo:	ے C	24 Hrs	8. Date of Bir		1101		place (State or Fo	oreian
	Funeral Director		5. Social Security Nu 237–28–01		6. Sex 1 № M 2 □ I		89 (In yrs. 11	ast birthday) Yrs.	Months		Hours	Min.	May 31	ay, Year)	20	Mary	Land	n orgin
		-	Usual Residence of															
	yland how		10a. State	10b. County			,	, Town or Lo								1	0d. Inside City L	
	e Mar		MD	Baltim	ore		Re1	sterst									1 □ Yes 2	7 140
	iff the	Dire	10e. Street and Num							p Code						What Cour	ntry?	
	s 23a	eral	18 Nicode	emus Ro		a a a da ma F	Transia II 6	140		136	lioponio Or	igin? (Cn	acifu Va s or No	US		e - Americ	can Indian,	
9	filed within 72 hours after death with the Maryland Hygiene.  ther than "natural", or items 23a or 28a-f show ther than "natural" or items 21a or 28a-f show ent, the Madical Evanti art rust be notified at	y Funeral Director	11. Marital Status 1 □ Never Marrie		ied 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	lForces? es 2□1 Give	945		was Deci lfYes,sp 1 ∐Yes		an, Mexica  Specify		ecify Yes or No Rican, etc.)		Blac	ck, White, v: white	etc.	
-00	2 hours atural", cal Evo	ted by	3 Widowed	15. Decedent	's Education	or Dates: 1	.971	16a. Dece	dent's Us	ual Occup	ation <b>U</b> II	k	ing	16b. K	ind of B	usiness/In	dustry	
21215-0036	within 7 ene. than "n	Completed	Elementary/Secor		colleg	e (1-4or 5 0	+)	life.	DO NOT	use retired	d)	SI OI WOIK	ng	Dept	. 0:	f Def	ense	
0	filed Hygi other ent, I		17. Father's Name (		Last)						18. Moth	er's Name	(First, Middle					
an	ld be tental ked c	To Be	Alson Ray	ymond E	Edgerton						Ella	Rac	hael Ed	lgert	con			
Maryland	shou and N s mar		19a. Informant's Na	me/Relationsl	hip (Type. Print)			19b. Mailii	ng Addres	s (Street	and Numb	er or Rui	al Route Numb	er, City	or Town,	, State, Zij	Code)	
Σ	and 2 salth in 27 is		Yong Edge	erton/s	spouse												1 21136	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time ZT is marked other than "natural", or Items Z3a or 28a-f show any injury or other traumatic event, the Madical Evantinal rulet by indifficed at once.		20a. Method of Disp 1 ☐ Burial 2 ☐ 4 ☑ Donation	Cremation	3 □ Removal fr	om State	20b. P	lace of Dispo emetery, crei	sition (Na matory or	ame of other plac	ce)	1	Date	20c. L	ocation -	- City or To	own, State	
Balti	permit. Departn Importa any Inju		21. Signature ROI	ne Service nald S	Lice	bir	for						655 W 21201	. Bai	ltim	ore S	Street	
	Physician	5 1ii	23a. Part 1 Enter the shock, at heal Immediate Cau (disease or condition	Final	_	at caused on each lin	9	n. Do not en	ter the mo	ode of dyi	mary ng, such a	s cardiac	or respiratory	arrest,			Approximate Interval Betwee Onset and Dea	
	/Medical Examiner		resulting in death)	9	a	to (or as		4									- 1	
			Sequentially list cor	nditions,	D	eptic									_		2 days	
	ted nsit	nin	Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or	mediate rlying injury	Due	to (or as	a consequ	dence on:										
, ,	ficate be executed I physician and s the burial-transit	I Examiner	that initiated events resulting in death) L		cDue	to (or as	a consequ	uence of):										-
68760,	tificate t ig physic as the b	edical			d					_								
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  Within 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	4 □ F	outcome ive birth regnant a Inknown	2 Feta	I death 3	⊒ Ectopic ⊒ Other (	pregnanc specify) _	су	_				ate of delive	very Day Yea	ar
ds, P.	w requires that the d been signed by the should be detached	by	Part II. Other signif				ut not resu	ulting in the u	inderlying	cause giv	en in Part	I.					the cause of dea obably 4 ☐ Uni	
S	v requ	ete	Atual	hlmel	latin								24a. Wa	s an	24b.	Were aut	opsy findings av	ailable
Re	: The law cate has page 2 s	Completed	Paroto to	CHACO	ght feu latur								auto per 1 □ Yes	opsy formed?		prior to codeath?	ompletion of cau	se of
ta	an: 7 tiffica tor, pa	Be C	25. Was case refer								26. Plac	e of Dea	h (Check only		0	10163	2/2410	
>	nysici lis cel direc		examiner? 1 ☐ Yes 2 🛣	No	Hospital:	<b>⊠</b> Inpatie	ent 2 🗆	ER/Outpatie	nt 3 🗆 I	OOA Oth	ner: 4 🗆 N	lursing H	ome 5 Res	sidence	6 □Ot	her (Spec	ify)	
0	ding Physician: h. After this certifice funeral director, p	اڃَا	27. Manner of Deat	h 5 🗌 Pendin	- /	ate of Inju Month, Da	ıry y, Year)	28b. Time of Injury	of	28c. Inju Wor	ry at rk?		28d. Describe	how inju	iry occui	rred		
sio	tendil eath. or: A the fu	catic	2 Accident	investig	gation				M		Yes 2	]No					10 1 H 1	
Division of Vital Records,	il or Atten after deatl Director: d in by the	ertification: To	4 Homicide	determ	ined 200. P	lace of Injudication	ury - At ho c. <i>(Specif</i>	ome, farm, st	reet, facto	ory, office			28f, Location City or To	(Street a own, Stat	ind Num e)	ber or Ru	ral Route Numbe	τ,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To Examiner: On t	the best he basis o nanner sta	of examina	wledge, dea tion and/or i	th occurrenvestigati	ed at the t	ime, date a opinion, de	and place eath occu	, and due to the	e cause( e, date ar	s) and n	nanner as , and due	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and	title of certifie						9c. Licens	se number			29d. D	ate sign	ed (Month	, Day, Year)	
			Ce	LS.	Ceulus	2 Yshi	i-Tar	nashrio	, MD	Res0					ly:	30,7	2009	
	9+1		30. Name and addr	,	who completed	cause of c	leath (Iten	n 23a) (Type,	Print)	, .			0 . 11.					
			Cecilia (		lamash	Poplat	VLD	S	inai	Ho	pital	04	13al fim	wil				
	Sta Registi		31. Date filed (Mon	IG 10	2009	negistr	ai s sigila	ha	Kad	,			Baltim					

			1 - State of Maryland /	Department of F Certificate of I		Hygiene, Reg. No.	2005	20000
	Physici		1. Decedent's Name (First, Middle, Last) Berry Adolphus Fisher, Jr.		2. Date of Monti	h Day	Year 2009	3. Time of Death 12:05.\(\Lambda\). M
1	/Medic Examir		4a. Facility Name (If not institution, give street and number) Gilchrist Hospice Center	4b. City, Town, or	Location of Death	4c.	County of Death	County
	Funeral Director		5. Social Security Number 6. Sex, 7. Age (In yrs. last in 245−28−4563 1 1 2 1 1 8 3		I If Under 24 Hrs.   8 Date	of Birth th. Day, Year) 27,1926	9. Birthpl Count ROCKW	ace (State or Foreign try) 1011, N.C.
	D	tor		own or Location			10	od. Inside City Limits
	th with the I 23a or 28a ist be roll	ral Director	10e. Street and Number 238 Cinder Road	10f. Zip Code	21093	I -	zen of What Count	
980	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Modifical Exarting regal by routiled at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 ☑ Yes 2 □ No.  If Yes, Give Year or Dates:		lispanic Origin? (Specify Yesan, Mexican, Puerto Rican, etc Specify:		14. Race - America Black, White, e Specify: Whit	etc.
Baltimore, Maryland 21215-0036	I within 72 ho giene. r than "natui if e Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Vice Pre	during most of working d)		nd of Business/Ind ercantile	
land ;	should be filed vand Mental Hygi s marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Berry Adolphus Fisher, Sr.		18. Mother's Name (First, M Dovie R. Bar		Surname)	
, Mary	tra tra		Mary Margaret (nee Helms) Fisher	238 Cinder Ro		m, Mary	yland 2	21093
timore	Pages nent of ant: If it		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	e of Disposition (Name of etery, crematory or other place Funeral Chap	el   2009	Fore		Maryland
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Euneral Service Lightsee Gar, In.	Panagard Address 2325 York	siderijatives F Road Timo	unerala nium, M	Crematic Maryland	n21093, P.A
* *	Physician /Medical Examiner		resulting in death)  Due to (or as a consequence)	netre	ng, such as cardiac or respirat		aty (	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and ts the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence consequence)  c. Due to (or as a consequence consequence)	ntis /	May May	1-telp	'MD'	grass
O. Box	law requires that the death certifical as been signed by the attending phy 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 9 □ Unknown	ath 3 Ectopic pregnanc	y		23d. Date of delive Month	ery Day Year
ords, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause giv	en in Part I. 23e.		se contribute to th	\
of Vital Records,	The ate h	Completed			1 🗆		prior to cor death?	psy findings available mpletion of cause of 2 □ No
Division of Vit	Attending Physician: 1 r death. ector: After this certifica ector; After this certifica by the funeral director, p.	ation: To Be	1 □ Natural 5 □ Pending (Month, Day, Year) 2 Naccident investigation (Month, Day, Year)	b. Time of lnjury 28c. Injury Worl	y at k? Yes 2 No The	Residence (cribe how injur	y occurred	tobing
Divis	a 를 늘 드	Certification:	4 Homicide determined building, etc. (Specify)	, farm, street, factory, office		or Town, State		Nicom m.D
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier  (Check only onle)  2 Medical Examiner: On the basts of my knowler (Check only onle)  2 Medical Examiner: On the basts of examination and manner stated.		opinion, death occurred at the	time, date and		the cause(s)
)	DUY!		30. Name and address of person who completed cause of death (Item 23)	De	58303	Au	vst 7	3003
	Sta	te_	AARON D CHANCES MM 60	701 N. Ch	vus St Por	Nocu	MO	
DH	Regist	rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	S. parks				

09-06158

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

lane randrey		State of Maryland / Departme 1- For State Certifica	ent of Health and Mental		200	9 2535
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)	no or bouin	Reg. 2. Date of Death	NO.	3. Time of Death
edical Exami		Duane D. Fandrey		Month E August 6, 20	Day Year DO9	1719 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De		4c. County of Death	
		Suburban Hospital	Bethesda		Montgomery	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		Hrs. 8. Date of Birth	(MM/DD/YYYY) 9. Birt Foreig	n
Director		None $ X \times 2 F $ 47	Yrs. Months Days Hours M	April 1	2, 1962 Co	<sup>untry)</sup> Canada
, h	ļ	Usual Residence of Decedent				40d Inside City Limite
м апу		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d at once.	ģ	D.C. Washi		- 140	033	
Mary r 28a ed at	Director	10e. Street and Number	10f. Zip Code	109	. Citizen of What Cour	ntry?
th the Ma 23a or 28 notified		3347 Quesada Street, N.W.	20015		nada	
ath wi	Funeral	11. Marital Status  1 Never Married 2 X Married Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		White, etc.	can Indian, Black,
erdea , ori	Fu	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify: Wh:	ite
2 hours afte "natural", Examiner	φ	or Dates:	Decedent's Usual Occupation (Give kind	of work done	6b. Kind of Business/l	
72 hou	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use	retired)		İ
0036 vithin 72 ene. er than	dmo	5+ N	aval Officer		Canadian M	lilitary
5-0 led w Hygie othe	ပေျ	17. Father's Name (First, Middle, Last)	18.Mother's Na	ame (First, Middle, Ma	iden Surname)	
21215-0036 and be filed within 7 Mental Hygiene, marked other than c event, the Nedian	a	Curtiss C. Fandrey		R. Pearce		
Should and M	욘		o. Mailing Address (Street and Number			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygievier Department of Heath and Mental Hygievier (Inportant of Item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once			347 Quesada Street N. of Disposition (Name of cemetery,		on, D.C. 2001 20c. Location - City or	
Baltimore, permit. Pages Lar Department of Hee Important: If ite		1 Burial 2 X Cremation 3 Removal from State cremat	ory or other place)	igust 10,	-	
Baltimore permit. Pages I Department of H Important: If i		4 Donation 5 Other Specify: Crema	omery torium, Inc.		Bethesda,	
Balt permit, Depart Import injury		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Robert A. Pumphrey F	uneral Home/	Bethesda-Che	vy Chase, Inc.
Physician		M01360  23a. Part I. Enter the disease, or complications that caused the death. Do no	7557 Wisconsin Avenue of enter the mode of dying, such as cardia			Approximate Interval
/Medical	y 78	failure. List only one cause on each line.  Immediate Cause (Final disease a Multiple Injuries				Between Onset and Death
`xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):				
		Sequentially list conditions, b.				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				1
	хаш	events resulting in death) Last Due to (or as a consequence of):				
ecuted and - transit		d				
60, ate be exe obysician e burial -	Medical	UNPENDED AMENDED				
ox 68760, eath certificate be er attending physician for use as the burial	W/	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pre	ornancy.	23d. Date of deliver Month	y Day <b>Y</b> ear
Box 687 death certific he attending p	ciar	past 12 months?  4 Pregnant at time of death		griancy	Month	Day Tea
Boy e death the att	Physician/I	1 Yes 2 No 9 Unknown 9 Unknown	0.000 (445-147)			
P.O. s that the gned by e detache	by P	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		acco use contribute to	
S, P.C iires that signed to d be deta					2 No 3 Pro	and the second
ords w requir s been s should	olet	1		24a. Was ar autops	y prior to	utopsy findings available completion of cause of
Cecol The law ate has l	Completed			perform 1 ✓ Yes 2		es 2 No
of Vital Records, ng Physician: The law require Mer this certificate has been si neral director, page 2 should b	BeC	25. Was case referred to medical examiner?	26.Place of Death (Che	eck only one)		
Vit hysica this o	ToE	1 Yes 2 No Inpatient 2 V ER/O			Residence 6 Othe	r:
n of ling P	Ë	1 Nobicel Au (Month, Day Year) 163	Time of Injury 28c. Injury at Work?  Ohrs 1 Yes 2 No.	28d. Describe ho Pedestrian st	ow injury occurred truck by auto	
IVISION or Attend after death Director:	atic	2 Accident Investigation	1 763 2 4 110		·	
Division tal or Attendir rs after death. al Director: A	Certification:	Suicide Could not be	arm, street, factory, office building, etc.	or Town, Sta	ate)	ural Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:		4 Homicide (Spanish Road 711	<u> </u>		/ilson Lane, Bethes	
Division of Vital Records, P.O. Box 68760, within 24 bours after the Physician: The law requires that the death certificate be executed within 24 bours after death. To the Inversal Direction: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner: On the basis of examination and/or i	ath occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cause ed at the time, date a	nd place, and due to t	ne cause(s)
To You	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (Mo	onth, Day, Year)
		Marie Malkards	O.C.M.E.		August 8, 2009	
		30. Name and address of person who completed cause of death (Item 23a)				
		Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore, M	1D 21201		
	tate	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	1-00			
Regis	trar	AUG 1 0 2009 Jenus J.	partel			
DHMH 17 Rev 1/2	2001	OF	RÍGINAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month

**Physician Funeral** Director

1 - For State Registrar

the a has been certificate After this

Day Year ikita 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Nown, or Location of Death 4c. County of Death Examiner 8. Date of Birth May 30, 1947 5. Social Security Number (In yrs. last birthday, 9. Birthplace (State or Foreign Months Days Hours Min M 2□F 62 076-40-5885 Germany Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a.f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Orange Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 71 Brook Road 10941 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No þ Specify Specify: White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Principle Process Engineer Covanta, Inc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Gorsky Alexandra Lopuchin ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Vera Gorsky, Wife 27 71 Brook Road, Middletown, NY 10941 permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other i other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Russian Orthodox 08/05/2009 4 Donation 5 Dother (Specify) Nanuet, New York 21. Signature of Funeral Service Licensee 22. Name and Address of Facility T. Harman Hannemann Funeral Home, Inc. 88 South Broadway, Nyack, NY 10960 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Latracranial HyperTension /Medical Due to (or as a consequence of) Examiner Lplracrap ral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran raumatic that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, CONTRACTOR IN PROPERTY OF A Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Vear 5 Other (specify) □Yes 2□No signed by t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 10:00 FM within 24 hours after upgare.

To the Funeral Director: 1 Wes 2 □ No 31-2009 ditch into 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Z1Z0L1 Marting burg determined 4 Homicide WORK DICKERSON 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) Critical lare Mysican 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22. /homas 6 rissom eene 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

3. Time of Death

Pleasa Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 05 Aug Month **Physician** Garland Henry Goldstraw 11:50 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMOR E If Under 1 Year | If Under 24 Hrs. AGNES HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 216-20-2476 84 Director June 17, 1925 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the "wedgal Examiner is an be notified at Director 1 ☐ Yes 2 ☑ No Baltimore Maryland Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 1203 Redcliffe Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1943-45 1 ☐ Yes 2 ☒ No Specify White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If item 27 is marked other than "na any Injury or other traumatic event. The second (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Communication Tech Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry O. Goldstraw Mary I. Graff ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Katzenberger Wife 1203 Redcliffe Road; Catonsville, MD 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 8/10/2009 4 Donation 5 Dother (Specify) Elkridge, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home of Catonsville, Inc. Fignature of Funeral Service Licens 1630 Edmondson Avenue; Catonsville, 23a. Part f. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEUMONIA Physician 15 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG CANCER CELL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed OBSTRUCTIVE PULMONARY DIE CHRONIC burial-trai resulting in death) Last Due to (or as a consequence of) physician the burial attending p for use as t Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, FIBRILLA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 2 No Vital 1 □Yes 20 Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA After this Certification: To of 27. Manger of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Division 5 ☐ Pending investigation Joital or Att.
4 hours after deat.
Teral Director; A 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number Hoing AUG. 86 2009 P 24069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Caton

900

32. Registrar's Signature

TINT

ATNG

Battimore, MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7 per In g894 8/10/09 TT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 2009 **Physician** 10:35 A™ GORDON MARJORIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 20 PALMER GREEN COURT BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign County) 8. Date of Birth 1/1/19/1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 212-26-1055 80 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or other traumatic event, the Medical Examiner must be notified at BALTIMORE MD N/A 1 X Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20 PALMER GREEN COURT USA 21210 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Completed by Specify: WHITE 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER GORDON PACKAGING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evones. CHOR LORETTA FRIEDLANDER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH GORDON / DAUGHTER LILLY STREET, FLORENCE, MA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 08/07/2009 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** entho /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print) arles St. Balto M& 2120x 670 MC

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
nend 10e per FH g894 8/10/09 TT
State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 11:55 A M ZENA AUGUST 5 GINSBERG 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOWSON GILCHRIST HOSPICE CARE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-28-1930 9. Birthplace (State or Foreign Min. Months Days 1 □ M 2 💢 F Hours MARYLAND 220-24-6452 79 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐Yes 2 No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7202 ROCK HILLS DRIVE, APARTMENT 210 USA 21209 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black. White, etc 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: WHITE 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DORA HURWITZ HYMAN HURWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3603 BARBERRY COURT, BALTIMORE, MD 21208 DEBRA LEVINSON/DAUGHTER 20b. Place of Disposition (Name of OHEB SHALOM MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-07-2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liceuree 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC MAY 2009 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ARTERY DISEASE 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

MD

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, II a Mudical Exacting the notified at once.

Baltimore, Maryland 21215-0036

sician and burial-tran attending physician for use as the buria signed by the a d be detached f page 2 s

Hospital or Attending Physician: The law requires that the death certificate be executed

has

To the Hospital or Attendle within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

P.O. Box 68760

Division of Vital Records,

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ZNo
9 ☐ Unknowh

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

	1 les 2,210
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPILE
27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigation	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	
_	

29a.	Certifier
	(Check onl.
	one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of c

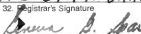
29d. Date signed (Month, Day, Year) D64395 August 5, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MO 6701 N CHARLES ST, SUITE 4105 BALTIMORE, MD 21204 31. Date filed (Month, Day, Year)

State Registrar

AUG



ABE GRINBLAT

12

			1 - State State Registrar	of Marylan		rtment of F tificate of I	lealth and N D <i>eath</i>		iene <sub>eg. No.</sub> 2 0 0 9	25361
	Physicia	an	1. Decedent's Name (First, Middle, Last)					Date of Deat     Month	h Dav Year	3. Time of Death
my	/Medic	al	ABE 4a. Facility Name (If not institution, give street and n		RINBLA		Location of Death	AUGUST	Day Year 2009  4c. County of Death	8:22 A M
	Examin	er	STELLA MARIS	ambery		TIMON			BALTIMORI	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
	Director		218-76-8821	88	Yrs.			01/28/1	921	POLAND
	ryland how		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 No
	he Ma 28a-f s otifiec	Director	MD BALTIMORE		ВА	LTIMORE		1	Og. Citizen of What Cou	
	with t		10e. Street and Number  2 HIGHSTEPPER COURT,	#603		2120	າຊ	'	USA	, , , , , , , , , , , , , , , , , , ,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 12. Was De Armed I	ecedent Ever in U. Forces? s 2 X No Give			ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WH	, etc.
200	72 hou natura lical E	ted	15. Decedent's Education (Specify only highest grade completed		16a. Dece	lent's Usual Occup	ation during most of work		16b. Kind of Business/I	ndustry
121	vithin 7	Completed		(1-4or 5+)	`life. L	OO NOT use retired	t)	ing	SAMMY¹S	
d 2	filed w Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last)		U	WNER	18. Mother's Nam	e (First, Middle, I		
/an	Aental Mental rked c	To Be	BERISH	GRI	NBLAT		Н	INDA	T:	INKELROIT
Maryland 21215-0036	2 short and 1 is marrauma		19a. Informant's Name/Relationship (Type. Print)		_	,			r, City or Town, State, Z	
ė,	1 and Health em 27		MALKA GRINBLAT / WIFE  20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of	i		LTIMORE, MI 20c. Location - City or 7	
altimore,	Pages nent of nt: If it		1 X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	m State		natory`or other plac E HEBREW		7/2009	REISTERST	OWN MD
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee		22	. Name and Addre	ss of Facility S	OL LEVIN	ISON & BROS KESVILLE, I	., INC.
	-		23a. Part I. En er the disease, or complication that shock, or heart failure. List only one set se on	t caused the death each line.	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	ON CANCE						
	Examiner			o (or as a conseq	uence of):					
	ji ji	iner	cause. Enter Underlying	o (or as a conseq	uence of):					
	xecute and I-trans	Examiner	that initiated events c.	o (or as a conseq	uence of):					
8760,	icate be executed physician and the burial-transit	dicalE	d	- (	,,.					
9	rtificating phy as the		IE EEMALE.						7	
O. Box	To the Hospital or Attending Physician: The law requires that the death certificath within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	outcome of pregna re birth 2□ Feta egnant at time of d known	al death 3 [	Ectopic pregnand Other (specify)	у		23d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to es 2 No 3 Pr	the cause of death?
Vital Records,	The law recate has be page 2 sho	Completed						24a. Was a autops perfor 1 □Yes	sy prior to o med? death?	topsy findings available completion of cause of 2 No
	ysician: The is certificate director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No Hospital: 1[	☐ Inpatient 2 ☐	1 FR/Outpatier	oth 3 DOA Oth	26. Place of Dea		ence 6 🛣 Other (Spe	city) HOCDICE
Division of	ding Phys h. After this ( funeral dir	Certification: To	27. Manner of Death 28a. Da	te of Injury onth, Day, Year)	28b. Time o				ow injury occurred	HUSPICE
Sior	Attendin er death. rector: Af by the fur	catio	2 Accident investigation			M 1□	Yes 2□No			
Σ̈́	or Attendafter death Director:	ertifi	determined 286. Pla	ice of Injury - At he ilding, etc. (Specif	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ıral Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical C	29a. Certifier 1 ☐ Certifying Physician: To t (Check only 2 ☐ Medical Examiner: On the one X Nurse Practitione	e basis of examina						
	To the within 2 To the comple	Me	29b. Signature and title of certifier	. 1		29c. Licens	se number	2	29d. Date signed (Monta	h, Day, Year)
			1 SAMSIA	NF		RI	19792		8/6/20	09
			30. Name and ad 1 ss of er on who completed ca				mr. course		202	
	Sta	ite	04 Data (1-1 (14-15 Day 1/4-1)	Desistror's Ciana	oturo	LLEY RD.	TIMONIUM	1, MD 210	093	
	Registi		AUG 1 0 2009 Len	www A	. your	Kal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:10 PM Month **Physician** CALVIN HOMA S Ull /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK FREDERICR (ENTER LIVINIE 60LDEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year Min. Months 214-32-2699 1 2 M 2 □ F 76 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show 1 Yes 2 No FREDERICK FREDERICK of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, if a Modical Examination to the intermetic event, if a Modical Examination of the control of the control in a modified in the modified in MD. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2170 USA MOTTER Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction là 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) VelVia THOMAS C. HOY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trauonce. 4-8TH ALLEY BOX 52 NEW MARKET MO ZITTY HACKEY (day 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1009 SMINUBURG SMITHSBURG CROM 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GARY L. ROLUNS FUN. Itom E 21. Signature of Funeral Service Licenses FREDERICA MO 21701 Rollin Huyd. 110 WEST SOURT ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CANCER UNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 whetes Sequentially list conditions, the distributions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Dav Year Pregnant at time of death 5 Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 风No 24a. Was an cate has t autopsy performed? Yes 2 No certificate 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

State Registrar

SIBTE A. KAZMI 31. Date filed (Month, Day, Year) AUG 10

29b. Signature and title of certifier

NU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only

814 TOIL MM 32. Registrar's Signature

and manner stated.

29c. License number

47951

29d. Date signed (Month, Day, Year)

House Ave Frederick, MD 21701

- 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #7 per Fb g894 8/10/09 TT
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Ce	rtificate of L	Death	Re	g. No.2 () () 9	25363
	Physici	an	1. Decedent's Name (First, Middle, Last)  ANNE	HUI	RWITZ		2. Date of Death Month AUGUST	4 200 <sup>Year</sup>	3. Time of Death 5:06 PM
	/Medic		4a. Facility Name (If not institution, give street and number)			Location of Death	7100001	4c. County of Death	
· ·	Examin	er	3420 ASSOCIATED WAY, #421		OWI	NGS MILLS		BALT	IMORE
ı	Funeral Director		5. Social Security Number 213-20-4305   6. Sex 1 □ M 2 □ F   7. Age (In yrs. le 94 8	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 10/11/1	9. Birth 924	nplace (State or Foreign untry) MD
	e Maryland 3a-f show	Director	Usual Residence of Decedent	, Town or Lo	GS MILLS				10d. Inside City Limits 1 □ Yes 2 1 No
	th with th	al Dire	10e. Street and Number 3420 ASSOCIATED WAY, #421		10f. Zip Code	117	10	og. Citizen of What Col	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Middel Even in a must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 <b>X</b> No	ispanic Origin? (Sp In, Mexican, Puerto Specify:	ecify Ye's or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	within 72 ho iene. • than "natu he Medien!	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	edent's Usual Occup kind of work done o DO NOT use retired CLERK	during most of work		16b. Kind of Business/I	·
Maryland 2	uld be filed Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last)  MORRIS RIMSON			18. Mother's Name		faiden Surname) RODGE	RS
ary	and N is mal		19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Number,	, City or Town, State, 2	(ip Code)
ž ô	and the search and 27 and 27 there tr		PAULA ANOFF / DAUGHTER		03 LIGHTF		BALTIM	10RE, MD 2	21209 Town, State
Baltimore,	t. Pages 1 tment of h tant: If ite		11 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	emetery, cre BREW F	matory or other place FRIENDSHIF	08/07	/2009	BALTIMOR	E, MD
Bai	permit Depar Impor any in		21. Signature of Funeral Service Licensee		8900 REI	STERSTOWN	RD., PI	SON & BROS. KESVILLE,	MD 21208
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leaving to immediate	uence of):	lan	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
68760,	rtificate be executed ng physician and as the burial-transit	Medical Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C		Ū				
P.O. Box 68		Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of dog 10 □ Unknown	Ideath 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of del Month	iivery Day Year
	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resu	ulting in the u	underlying cause giv	en in Part I.	23e. Did tot	bacco use contribute to es 2 □ No 3 □ Pi	o the cause of death?
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attendicompletely filled in by the funeral director, page 2 should be detached for use	Completed			-		24a. Was a autops perforr	prior to death? 2 No 1 Yes	utopsy findings available completion of cause of
ΖĦ	s certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  Hospital: 1 ☐ Inpatient 2 ☐	FB/Outpatic	ent 3 DOA Oth	er.	th (Check only on	ence 6 ⊡Other (Spe	acify)
ion of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Certification: To	27. Manner of Death 1	28b. Time o Injury	of 28c. Injur	ry at		ow injury occurred	
Divis	tal or Atters a site of a Directo	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	(y) 			City or Town		
	To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the	Medical (	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my kno 2 ☐ Medical Examiner: On the basis of examina and manner stated.	wiedge, dea ition and/or i	nvestigation, in my	opinion, death occu	rred at the time, d	date and place, and due	e to the cause(s)
	To t with To t	Σ	29b. Signature and title of certifier  Belle	)		+31615	985	29d. Date signed (Mont	nn, Day, Year)
7			30. Name and address of person who completed cause of death (Item	-	, Print) Walka	- Are	Aut	timbe w	& ons an
	Sta Regist		31. Date filed (Month, Day, Year)  AUG 10 2009  31. Registrar's Signa	1. pa	Wed				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene  $\angle \ \cup$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1535 manton 2009 6 August Holtzman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1**X** M 2□ F 214-76-9570 MD 04-04-1958 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event. 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 1 □Yes 2X No Funeral Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6508 GREENSPRING AVENUE 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES REPRESENTATIVE KEEBLER-SUNSHINE COMPANY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DANIEL HOLTZMAN SYLVIA ROSEN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6508 GREENSPRING AVENUE, BALTIMORE, MD 21209 LYNNE GROSSMAN/SISTER 20b. Place of Disposition (Name of ANSHE EMUNAH ATTZ 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08-07-2009 | BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) CHAIM CONG. 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to or as a consequence of): **Examiner** Posumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed B-cell lumphoma
Due to (or as a consequence of): and burial-trar the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director: After t 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one)

Kelly

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

within 2

South Greene

and manner stated.

22

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norsworth

AUG 1 0 2009

MD

2. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

P22955

Street, Baltomore, Maryland 2120

29d. Date signed (Month, Day, Year)

August 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05998 State of Maryland / Department of Health and Mental Hygiene Stanley Joines Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle Last) Physician/ August 1, 2009 0205 hrs Medical Examiner tb. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) 1915 West Lafayette Avenue **Baltimore** WA 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Country) Months Hours Min. Director 213-04-M 20 Usual Residence of Decedent 10d. Inside City Limits Yes 2 Lino or items 23a or 28a-f show must be notified at once. altimore Destimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e. Street and Numb Mode 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married Yes Divorced If Yes, Give Year 2 / No 1 Yes specify. Widowed ≦ or Dates 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 27 is marked other than " å (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Nar 19b. Mailing Address tlemoor Windsor 20c. Location - City or Town, State or other tra 20a. Method of Disposition 20b. Place of Disposition (Name of crematory or other place) 2 Cremation 3 0808-0 Donation 5 Other Specify 21. Signature of Funeral Service License Approximate Interval ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and ly one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician for use as the burial Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the Live birth Fetal death Ectopic pregnancy Month Day past 12 months? Pregnant at time of death Other (Specify) 5 signed by the atte 1 Yes 2 No 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Yes 2 ✔ No 3 Probably 4 Unknown Completed this certificate has been s director, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital:, Residence 6 🗸 Other: Scene Nursing Home 5 2 ER/Outpatient 3 Inpatient 1 Yes ပ

Division of Vital Records, P.O.

To the Hospital or Attending Physician: After this 24 hours after death. To the Funeral Director:

Certification:

Medical

27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month: Day, Year) FOUND: Aug 1, 2009	28b. Time of Injury FOUND: 0200 hrs	28c. Injury at Work?  1 Yes 2 ✔ No	Subject assau						
3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, street, facto e / Rowhouse	ry, office building, etc.	or Town, Sta	cation (Street and Number or Rural Route Number, Ci Town, State) Vest Lafayette Ave, Baltimore, Md					
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Month, Day, Year)					
alm	15	7	O.C.M.E.		August 1, 2009					

111 Penn Street, Baltimore, MD 21201

Zabiullah Ali, M.D. 31. Date filed (Month, Day, Year) State

32. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

Registra

Year

No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#20a-c, perFH, G894, 8/10/09 WS
State of Maryland / Department of Health and Mental Hygiene
amend #20c&d Per FH G895, 9/08/09 JH amend #20cod Per FH G 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Year **Physician** 2:20 A M Peter Tsakanikas Peter James August aka /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country)
 New York If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min Months 1 XM 2 ☐ F Yrs. July 20, 1931 78 Director 218-94-7461 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show event, the Medical Exercitive roust be notified at 1 ☐Yes 2X No Director Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 23a United States 20886 19301 Watkins Mill Road death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc 1 XYes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or If Yes, Give Year or Dates: Korea 1 ☐Yes 2 XNo Specify: Specify: þ White 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other trainmant. 5+ Computer Systems Inventor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vasilia Trikirioti James Tsakanikas 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10513 Rivers Bend Lane, Potomac, Maryland 20854 Betty Sullivan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Triangle, Virginia 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico National Cem 9/10/2009 Bethesda, MD 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service Licensee M00198 Approximate Interval Between Onset and Death 23a. Part1. Ent3 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 2 days Physician Hypotension disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Weeks Sequentially list conditions, if any, leading to immediate cause. Enter the cause Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit and Due to (or as a consequence of) physician a the burial-t P.O. Box 68760. Physician/Medical attending p for use as t IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) TYes 2 No detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 page 2 should be Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Coagulopathy, Urosepsis, Pneumonia autopsy performed' 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident fter dear 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide completely filled in by determined 4 Homicide Hospitallor 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature ar title of certifier 29c. License numbe 30. Name and a ress of person we completed cause of death (Item 23a) (Type, Print)

State Registrar Sujatha Ramaseshan, M.D.

32. Registrar's Signatu

9901 Medical Center Drive Rockville, Maryland 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 14:38 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ou nion Memora 9. Birthplace (State or Foreign

Sorth Caroline 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 58-35 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☐ Yes 2 No Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. 10 2 Specify: 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Circle Dunjab 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Derial 2 ☐ Cremation 3 ☐ Removal from State ansdame 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Servi Approximate Interval Between Onset and Death 23a. Part . Extradisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, o heart failure. List only one cause on each line. Immedia e ause (Final disease or condition resulting in death) **Physician** HYPERCAPMIC RESPIRATORY 24 HOURS /Medical Due to (or as a consequence of): Examiner UMKNOWN ABUSE THANOL Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be executed UNKNOWN SCHIZOPHRENIA Due to (or as a consequence of) signed by the attending physician at the detached for use as the burial 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of deaty?

1 ☑Yes 2 ☐ No 24a. Was an page 2 s autopsy rperformed? Yes 2 □ No this certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after usa...

To the Funeral Director; After this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KT 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARK UNION HOSPITAL, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July 30 2009 6:30 PM Vernon Donald Knickman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline 9318 Mike Street Denton 8. Date of Birth (Month, Day, Year, 3/10/1934 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 ☑ M 2 ☐ F Months Days Hours 75 Director 215-30-9294 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ir than "natural", or items 23a or 28a-f show the Madical Examinar roust be notified at 1 ☐ Yes 2 X No Director Caroline Denton MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with U.S.A. 21629 9318 Mike Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🕅 No If Yes, Give Year or Dates: Specify: Specify: White ģ 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Fisher Knickman Rose Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 414 Glenwood Avenue, Glen Burnie, MD 21061 Shirley Storm/ Niece Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2009 Hanover, Maryland Anatomy Gifts Registry 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensles 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Sist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** unknown Severe CAD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease) ner Due to (or as a consequence of): death certificate be executed Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical attending pl IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DM II 24a. Was an certificate has page 2 autopsy The 2 X No 1 ☐ Yes 2 X No of Vital 1 □Yes Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 🔀 Natural 5 ☐ Pending after death.

I Director: Af d in by the full 1 ☐Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2009 D0068045 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 609 Daffin Lane, Denton, MD 21629 Kavita Mohan M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 2009 S. park Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Physician 20:45 M Paul Leahu 2009 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center Balt more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 04/20/1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Massachusetts 1**⊠** M 2□ F Months Days 220-32-5991 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redified at once. 1 ☐ Yes 2 No Director MD. Howard Mount Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1880 Florence Road 21771 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 🔀 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Building 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Leahy Margaret Walsh ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta A. Leahy/Wife 1880 Florence Road, Mount Airy, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Cremation Services: 08/09/2009 Hanover, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee M01197 Zama C. Hardesty 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): **Examiner** Epidural Abscess Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **N**0 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

29b. Signature and title of certifier

Dinalsmail 31. Date filed (Month, Day, Year)

AUG 1 0 2009

DHMH 17 Rev 1/2001

parker

MD

Registrar's Signature

22 South Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P22955

Street Baltimore, MD

7,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 07, 2009 August 3:25 P.M Alan Charles Luebbert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Baltimore County Lorien Mays Chapel Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 11 M 2□ F Months Hours 74 493-34-3149 Director St. Louis, MO. Jan.02,1935 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is americal or than "instural;", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Baltimore County Sparks Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21152 United States 2 Far Corners Loop Funeral 12. Was Decedent Ever in U.S. Armed Forces? rElyes 2□ No Korean If Yes, Give Year or Dates: Conflict Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Fire Equipment Dispatcher City of St. Louis 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold Luebbert Marian Esther Loosmore 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Ann(nee Meckfessel)Luebbert 2 Far Corners Loop Sparks, Maryland 21152 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 2009 Evans Funeral Chapel: 4 □ Donation 5 □ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kearl estre **Physician** ears disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit ousease attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 9□Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ÎNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 1 Natural Injury 5 Pending M 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type\_Print)

UG 10 2009 Lever B. park

DHMH 17 Rev 1/2001

6701 N Charles

Mreel

			1 - For State Registrar		artment of Health and N rtificate of Death		ene 009	25371
	Physici	an	1. Decedent's Name (First, Middle, Last) Elvira Vivianni Telles	To Plana		2. Date of Death	4 <sup>Day</sup> 2009 <sup>ear</sup>	3. Time of Death 8:27 pm
- way	/Medio Examir	cal	4a. Facility Name (If not institution, give street and Greater Baltimore Balt	number)	4b. City, Town, or Location of Death Towson		4c. County of Death	1
	Funeral Director		5. Social Security Number 125-36-4547 1□ M 2점	7. Age (In yrs. last birthday) 95 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, ) Feb. 20, 1		place (State or Foreign ntry) Brazir, de Janeiro
	e Maryland 8a-f show ptified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Harford County	10c. City, Town or Lo				10d. Inside City Limits 1 □Yes 2♠No
	with th		10e. Street and Number 1500 Scarlet Oak Court		10f. Zip Code 21014	100	g. Citizen of What Cou United S	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show entry fujury or other treumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 1 Yes.	s 24 No	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: Whi	ican Indian, etc.
21215-0036	within 72 ho iene. • than "natur ire Medical	Completed	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  Colleg 5	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) dustrial Chemist	sing 16	6b. Kind of Business/li Chemis	·
Maryland 2	uld be filed Mental Hyg irked other itic event, I	To Be C	17. Father's Name (First, Middle, Last) JOSE F. 'Pelles		18. Mother's Nam Luisa V	e (First, Middle, Ma ivianni	aiden Surname)	
, Mary	and 2 sho lealth and I m 27 is me her treuma			aughter) 150	ng Address (Street and Number or Ru O Scarlet Oak Cou	rt Bel	Air, Mary	land 21014
Baltimore,	L. Pages 1 trnent of H tant: If iter		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro  4 ☐ Donation 5 ☐ Other (Specify)	Evans Fun	eral Chapel Aug 2	ust 09, 009 F	oc. Location - City or Torest Hill	,Maryland
Bal	Depar Impor eny Ir		21. Signature of Funeral Service Licenses	1	eaceful Alternati 2325 York Road			On Ctr., P.A 21093
	cate be executed  /Medical  Examiner  the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Lines Underthing Cause (Disease or injury that initiated events	1	ancer			Interval Batween Onset and Death
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending place the Funeral Director. After this certificate has been signed by the student of the formation of the funeral director, page 2 should be detached for use est to completely filled in by the funeral director, page 2 should be detached for use est	Physician/Med	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	very Day Year
rds, P	quires that en signed b uld be deta		Part II. Other significant conditions contributing t	o death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	
al Records,	ysician: The law requir is certificate has been s director, page 2 should	Completed by					ed? prior to death?  No 1 □ Yes	opsy findings available ompletion of cause of 2 □ No
f Vital	Physicia this certi al directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital:	☐ Inpatient 2 KER/Outpatie	Othory	th <i>(Check only one)</i> ome 5 ☐ Residen	nce 6 Other (Spec	rify)
Division of	vttending Phy death. ctor: After thi y the funeral o	Certification:	1 Natural 5 □ Pending (A 2 □ Accident investigation	ate of Injury fonth, Day, Year) 28b. Time o Injury	f 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how		
Divis	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		l l	ace of Injury - At home, farm, str illding, etc. (Specify)	).	City or Town,		
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Examiner: On tr one) and n		th occurred at the time, date and place overstigation, in my opinion, death occurred to the contract of the co	rred at the time, da	te and place, and due	to the cause(s)
	<b>5</b> vit	-	29b. Signature and title of certifier	Jan.	29c. License number	. 29	d. Date signed (Month	, Day, Year)
•	41		30. Name and address of person who completed of		Print) I N. CHARLES ST	TOWSO	NMD 21	204
	Sta Regist		31. Date filed (Month, Day, Year) 3:	2. Registrar's Signature	baris		To the good (g	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 07, 2009 4c. County of Death Jeanne Edith Larson 2009 1:02 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Center Towson Baltimore 8. Date of Birth (Month, Day, Year) 08.05.1917 Birthplace (State or Foreign Country) If Under 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Davs Hours 1 □ M 2 💢 F 333.09.9146 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Mydical Examiner must be notified at once. 10a State 1 Tes 2 No Director MD Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 301 N. Beachwood Funeral - A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 to Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Public Libbrary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dr. Albert C. Keller Mable B. Osborne ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 North Beachwood, Catonsville, ace of Disposition (Name of Date 20c. Location - City) Chrystie Adams/Daughter MD 21228 20b. Place of Disposition (Name of Ricemetery, organization) or other place)
Memorial Park 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State al Park O8.11.09 Batavia. IL
22. Name and Address of Facility CAFA/Stephen D. Lohrmann PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO1443 8717 Green Pastures Dr. Balto., MD 21286 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due I (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) be executed ending physician and use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical ettending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the e 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 100 3 Probably 4 Unknown 1 ☐ Yes been si should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 🗆 No 1 ☐ Yes 1 ☐ Yes sepital or Attending Physician: Ti hours after death. Ineral Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 1 No Other: 4 Nursing Home 5 Residence 6 Other (Specify WY) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Peath 28a. Date of Injury (Month, Day, Year) 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 6701 N. Charles ST TONSONMO

State Registrar 31. Date filed (

onth, Day, Year)

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ress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** WILLIAM E. MEARLE 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore uare cial Security Number last birthday, Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Days Hours Vear Months 1 ★ M 2 🗆 F 85 **Director** 04/15/1924 RHODE ISLAND 213-20-3948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes & No Director BALTIMORE PERRY HALL MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4620 A FORGE ROAD 21128 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☑No þ Yes. Give Specify WHITE 3 ₩idowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th GRADE TICKET COLLECTOR RACE TRACK permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked other any Injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNAVAILABLE UNAVAILABLE ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM MEARLE, JR./SON 7335 CONLEY STREET BALTIMORE, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial / 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) DULANEY VALL. MEM. GAR. 8/11/09 COCKEYSVILLE, MD 21. Signature of runeral ServiceyLinknee 22. Name and Address of Facility MO1139 THE JOHNSON FUNERAL HOME P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Part 1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ardio Pulmonary resulting in death) /Medical Due to (or as a consequence of): Examiner vocardia Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dae to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Records, Division of Vital

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive, Baltimore Maryland 21237 Adam Goodman, MD 31. Date filed (Month, Day, Year)

AUG 1 0 2009

2. Registrar's Signature

RES0000

8/6/09

09-06172 Stephen F. Mace

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physic	ian/ 1. Decedent's Name (First, Middle,Last)  2. Date of Death North										Year	3. Time of Death			
edical Exam	uner	<u> </u>						L 41 - 0'1	T		( D - a4b	August 7,	2009		1342 hrs
		4a. Facility Name (if Greater Balt						Tows		Location o	r Death			County of Deat altimore Co	
Funeral		5. Social Security N		6. Sex		e (In yrs. la	ast birthday)		er 1 Year	r If Under	r 24Hrs.	8. Date of Bir			irthplace (State or
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any		10a. State	10b. County			10c. City,	Town or Loca	ation				-			10d. Inside City Limits
and show	b	Maryland	Baltin	nore Co	ounty	]	Baltimo	ore							1 Yes 2 X No
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ter dear '', or i		3 Widowed		orced If Yes, G	Yes 2 live Year	X No	1	Yes 2	Z V No	specify:			s	Specify: Wh	nite
urs af Itural	db	15. Decedent's Ed	lucation (Spec	or Dates ify only highe	st grade con	npleted)	16a. Decede	ent's Usua	Occupati	ion (Give k				nd of Business	/Industry
6 72 hc m "m; cal Ex	Completed	Elementary/Seco	ndary (0-12)	Colf	lege (1-4 or	5+)				DO NOT		ed)		Music	
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<b>21215-0036</b> Und be filed within 72 hours after death with the Maryland Mantal Hygiene. marked other than "natural", or items 23a or 28a-f she event, the Medical Examiner must be notified at once	ပိ	17. Father's Name (	(First, Middle, liam Ro	,	so In							(First, Middle, I Mary	Maiden S <b>Jone</b>	· ·	
2121 ould be fil Mental I marked	To Be	19a. Informant's Na				•	19b. Maili	ng Addres	s (Stree					y or Town, Stat	te, Zip Code)
MD 21 d 2 should lth and Me n 27 is man		Louis F.	Fried	nan, Es	sq. (F	.R.)									nd 21204
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Baltimore, permit. Pages 1 a Department of He Important: If ite thjury or other tr					AD.					The second second second					
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	F	1 ✓ Yes 27. Manner of Deat	No h	28a	. Date of Inju	ıry	28b. Time of			ry at Work		28d. Describe			G: .
	<u>E</u>	1 X Natural	5 Pendi	ing	(Month, Day, Y	'ear)			1 \	Yes 2	No				
			Inves	tigation	e. Place of In	jury - At h	ome, farm, str	reet, factor	y, office b	uilding, et	c.			nd Number or F	Rural Route Number, City
- e - p	ificat	2 Accident 3 Suicide	. 🖂	i not be							J	or Town, \$	State)		
Pita ours fille	Certifical	3 Suicide 4 Homicide	6 Could	not be	pecify)										
Hospi 24 hou Funer tely fil	cal Certification:	3 Suicide 4 Homicide 29a. Certifier 1	6 Could determ	mined (Samuel)	the best of m	y knowled	ge, death occ	curred at th	ne time, da	ate and pla	ace, and	due to the caus	se(s) and	f manner as sta	ated.
To the Hospi within 24 hou To the Funer completely fil	edical Certifica	Suicide  4 Homicide  29a. Certifier 1 (Check only one) 2	6 Could determine Certifying Ph	not be mined (Spanysiciam): To the and ma	the best of m	y knowled mination a	ge, death occ nd/or investig	ation, in n	ny opinion	n, death oc	ace, and curred a	due to the caus t the time, date	and plac	ce, and due to	the cause(s)
To the Hospi within 24 hou To the Funer	Medical Certificat	3 Suicide 4 Homicide 29a. Certifier 1	6 Could determine Certifying Ph	not be mined (Spanysiciam): To the and ma	the best of m	y knowled mination a	ge, death occ nd/or investig	ation, in n	ny opinion 9c. Licens	e number	ace, and curred a	due to the caus t the time, date	and place	oe, and due to Date signed (M	the cause(s)  fonth, Day, Year)
To the Hospi within 24 hou To the Funer completely fil	edical Certifica	3 Suicide 4 Homicide 29a. Certifier (Check only one) 2	6 Could determine Certifying Phedical Exame	not be mined (S/nysiciam: To temper:On/he and ma	the best of m basis of exa inner stated.	mination a	nd/or investig	ation, in n	ny opinion	e number	ace, and curred a	due to the cause the time, date	and place	ce, and due to	the cause(s)  fonth, Day, Year)
To the Hospi within 24 hou To the Funer	edical Certifica	Suicide  4 Homicide  29a. Certifier 1 (Check only one) 2	6 Coulc determined to the control of	not be mined (S/nysiciam: To temper:On/he and ma	the best of m basis of exa inner stated.	mination a	nd/or investig	gation, in n	opinion O.C.I	n, death occies number	curred a	due to the cause the time, date	and place	oe, and due to Date signed (M	the cause(s)  fonth, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2537 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year August Charles Walter McCray, Jr. 19:45 PM 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Union Memorial Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 213-16-5999 Months Days Hours Min. 89 July 18, Mary land Usual Residence of Decedent 10b. County Maryland 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5932 Theodore Avenue 21214 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 🙀 No Specify. White 3 ☐ Widowed 4 ☐ Divorced

16a. Decedent's Usual Occupation

Factory Worker

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Heart

2 ER/Outpatient 3 DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

omplete

Schemic

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

and manner stated.

ta

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date of Injury (Month, Day, Year)

9 Unknown

Due to (or as a consequence of):

Due to (or as a consequence of)

ardiomyopath

Gardens of Faith Cemetery

3 Ectopic pregnancy

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

nion

29c. License number

1 ☐ Yes 2 ☐ No

5 Other (specify)

(Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Baltimore Maryland

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24a. Was an

1 □ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Memorial

autopsy

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Factory

18. Mother's Name (First, Middle, Maiden Surname) Elsie Eva Schmidt

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5932 Theodore Avenue Baltimore Maryland 21214

8/7/09

22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214

**Physician** · /Medical

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai

**Physician** 

/Medical

Director

Funeral

Completed by

Be

၉

Examiner

Physician/Medical

ģ

Completed

Be

Certification: To

cal

IF FEMALE

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Charles W. McCray, Sr.

21. Signature of Funeral Service Licensee

19a. Informant's Name/Relationship (Type. Print)

Marilyn McCray Holmes/ Daughter

1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)

12

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐Yes 2 ☐ No

9 Unknown

in the past 12 months?

25. Was case referred to medical examiner?

29b. Signature and title of certifier

ama

1 ☐ Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

disease or condition resulting in death)

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite. Modical Examinism must be notified at

Baltimore, Maryland 21215-0036

Examiner

P.O. Box 68760, attending the signed by Division of Vital Records, has certificate this

Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar use as the for 1 in by the funeral director, after death. Director: After To the Hospital within 24 hours a To the Funeral D

3

5 Pending investigation

6 Could not be determined

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Whitney 10.50 PM Nyman 2009 4 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (enter Baltimore Johns Lopkins Bayview Medica 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye June 21, 6. Sex Birthplace (State or Foreign Country) Year) 1□ M 2XF Months Days Hours Maryland 47 1962 212-92-2438 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 8043 North Boundary Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No þ If Yes, Give Year or Dates: Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph W. Green Janice M. Wright ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 8043 North Boundary Road Dundalk, Maryland 21222 William F. Nyman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gdns. of Faith Cemetery 8/7/2009 Rossville, Maryland 4 Donation 5 ☐ Other (\$pecify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Cause (Fine) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or as a consequence of): Renal Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a conse wence of Exami Chronic Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Ye ar 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🗹 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural

P.O. Box 68760 5 attending physician for use as the buria the signed by t t be detach Division of Vital Records, page certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Funeral

Director

show

28a-f

23a or

other traumatic event, the Medical Examinar hast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatin event

**Physician** /Medical

**Examiner** 

Baltimore, Maryland 21215-0036

death with the Maryland

Physician/Medical à Completed Be

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

29c. License number Res-600

ND

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Home-dap4940 EasternAre

31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated.

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Month Margaret M. Nee M 2009 August 6 1939 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 1 X F Director 578-11-4687 74 1934 Nov. 6, Canada Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h County r than "natural", or items 23a or 28a-f show 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Mass. Barnstable Yarmouth Port 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Hawthorne Road 02675 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of traumatic even 2 John A. MacIsaac Willietta McAdam 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and inportment of Health Important: If item 27 any injury or other tr Coleman J. Nee / Husband 5225 Pooks Hill Rd., Apt # 1414S, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State August 8, 4 ☐ Donation 5 ☐ Other (Specify) 2009 Bethesda, Maryland Crematorium, Inc. 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Perri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Year Gastric Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Day Year 5 ☐ Other (specify) P.O. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 is certificate has been s director, page 2 should it 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed<sup>a</sup> Vital 1 ☐ Yes 2 ☐ No 1∐Yes 2X∏No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 IX Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To ð After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Attending 1 X Natural 5 Pending death. Hospital or Attend 24 hours after death Funeral Director: 2 Accident investigation 1 ☐ Yes 2 ☐ No by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled in e Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51616 August 7, 2009

State Registrar

DHMH 17 Rev 1/2001

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RABAR

5454 Wisconsin Ave. #1300, Chevy Chase, Maryland 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Nelson Kalil, M.D.

Registrar

State

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year **Physician** John Louis Plaine 2009 3:47 A. August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Dove House Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex XX M 2□ F 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Min Months Days 59 Yrs. Director 215-56-6232 June 23, 1950 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, I'm Medical Exminer must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No Maryland Carroll Manchester 10e. Street and Number 10g. Citizen of What Country? United States 10f. Zip Code 3125 Main Street, Funeral Apt. A Rear 21102 America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married XX Married 1 ☐ Yes 2 XNo Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lĺth Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Charles Plaine Nellie Robertson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy A. Plaine (Wife) P.O. Box 712 Manchester, Maryland 21102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State August 10, permit. Page:
Department o
Important: If i
any Injury or XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 6 ☐ Other (Specify) 2009 Kirkridge Church Cem. Manchester, Maryland 21, Signature of Fynaral Service Licensee Eckhardt Funeral Chapel, P.A. Millin 3296 Charmil Drive, Manchester, Maryland 21102 3a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LUNG dis se or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an 1 □Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 AOther (Specify) NUE HUUSE 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the distribution of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie one) and manner stated. 29c. License number 29b. Signatur 29d. Date signed (Month, Day, Year) DOU67468 address of person who completed cause of death (Item 23a) (Type, Print) NARANG ENTER CWESTMINISTER, LAD 2115 31. Date filed (Month, Day, Year) AUG 10 2009 State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

			ricas	State of Ma						-		-	
			For State	State of Ma	arylariu		rtificate o			wentai ny	-	241114	25380
			Registrar  1. Decedent's Name (First, Middle,	l ast)		061	- Incate o	T DCC		2. Date of D	Reg. No	1,1-	3. Time of Death
	Physici	an	Millie	Pettu	1011					Month Augus	Da	y Year	3:47AM
-	/Medic Examin		4a. Facility Name (If not institution,		/ay		4b. City, Town	or Loca	tion of Dea			. County of Dear	th
1	Examin	er	Morth west	hospital	2		Ramo		rown			Ba <b>1</b> ti	more
	Funeral			. Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Year Months Day	ar If U	nder 24 Hrs	(Month, D	av. Year	9. Biri	thplace (State or Foreign Duntry) North
	Director		240-70-8525	1 □ M <b>X</b> IXF	61	Yrs.	World S Day	75 110	uis Will	March	26,	1948 (	Carolina
	pur 🙀		Usual Residence of Decedent  10a, State 10b, County		10c City	Town or Lo	ecation						10d. Inside City Limits
	sho	ō	,	imore	, co. oky,		stersto						1 □Yes XIXNo
	28a-1	rect	10e. Street and Number	IMOLE		кет	10f. Zip Code				10g. Ci	tizen of What Co	puntry?
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Exactive must be multied at	Completed by Funeral Director	32 Ewing Dr.						136			U.S.	_
	ms 20	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of			Specify Yes or Note to Rican, etc.)	0-	14. Race - Ame	erican Indian,
ယ္	r iter	Fur	1 ☐ Never Married XX Married	Armed Forces? 1 ☐ Yes XX	No		lf Yes, specify C 1 ⊡Yes 💥 N		exican, Pue ec <i>ify:</i>	to Rican, etc.)		Black, White	
21215-0036	ral", c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			TLIYES 28431	NO SP	эспу:			Specify:	Black
5-0	72 hc	etec	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual Oci kind of work doi DO NOT use ret	cupation ne during	most of wo	orking	16b. k	(ind of Business	/Industry
121	/ithin	ldm	Elementary/Secondary (0-12)	College (1-4or 5	5+)							frang # 1	
	filed withir Hygiene. other than	ပ္ပ	17. Father's Name (First, Middle, La	et)	1	-1cei	ised Pr			me (First, Middle	e. Maidei	Health	Care
anc	d be f	Be		r Jenkins				10.1		De11			
Maryland	2 should be fi and Mental I is marked of aumatic eve	그	19a. Informant's Name/Relationship		T	19h Mailir	na Address (Stre	eet and N				or Town, State,	Zip Code)
	rtra		Rosalind Smith		er		,						MD 21061
Baltimore,	ges 1 and 2 t of Health If Item 27 i or other tra		20a. Method of Disposition				osition (Name of matory or other p		-	Date	7	ocation - City or	
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alti	permit. Pages 'Department of Important: If Ite any injury or of once.		21. Signature of Funeral Service Lie	ensee	111211	2:	2. Name and Ad	dress of F	acility <b>E</b> C	khardt	Fun	eral Ch	napel P.A.
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			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	emplications that caused by one cause on each li	d the death. ne.	Do not en	ter the mode of	dying, suc	ch as cardia	ac or respiratory	arrest,		Approximate Interval Between
ve.	Physician		Immediate Cause (Final disease or condition	- Multis	le or	aan :	system	Cail	ure				Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):				7			
	Examine	-	Sequentially list conditions,	Due to (or as		11111	Tory re	Spor	168 0	Indron	10		
	ited nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0		,	a el ra	0	201	ure			
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68	leath certificate attending physi i for use as the l	ledi											
Вох	th cer endir	J/L	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			⊒Ectopic pregna	ancv				23d. Date of de	
Э.	deal	sicis	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify					Month	Day Year
P.0	at the ded by the stacked	Physician/Medi	9 Unknown				1.12		D	22a Die	Itabaaaa	una contributo t	o the cause of death?
S,	ires tha signed I be det		Part II. Other significant condition	1	S&Q.S	-	nderlying cause	given in i	Part I.	120		1	robably 4 Unknown
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<b>3ec</b>	e law has l	Completed by	Carcuaty arien!	0185085						24a. Wa	s an opsy formed?	24b. Were a prior to death?	utopsy findings available completion of cause of
a	lcian: The la certificate ha ector, page ?		Anoxic brain 1	gary						1 □ Yes	2 LIN	o 1 □Ye	s 2 🗆 No
of Vital Records,	slcian: certific irector,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ont alle	B/Outnatia	nt 3 DOA	Othor		eath (Check only		6 ☐ Other (Spe	:6-1
	g Phys er this eral dii	n: To	27. Manner of Death	28a. Date of Inju	iry 2	8b. Time o	f 28c. II	niury at	□ Nursing	28d. Describe			ecity)
ion	ath. T: Afte	atio	1 Matural 5 Pending 2 Accident investiga	(Month, Da	iy, Year)	Injury		Vork? I ∐Yes	2  No				
Division	or Attending after death. Director: Afte in by the fune	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ury - At hom	ne, farm, sti	reet, factory, offic	ce		28f. Location	(Street a	nd Number or F	tural Route Number,
Ö	ital or is after al Dir led in	Certification:		Danishing, or	. (					.,,			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	cal	(Check only 2 Medical E)	Physiclan: To the best taminer: On the basis of	of my knowl of examination	ledge, deat on and/or ir	th occurred at th	ie time, da ny opinior	ate and pla	ce, and due to th curred at the time	ne cause( e, date ai	s) and manner and place, and du	as stated. e to the cause(s)
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and manner st	ated.		29c Lic	ense num	nher		29d D	ate signed (Mon	th. Day. Year)
	<b>5</b> ≥ 5 8	_		UMO					162		1	in 11 t	9 2.009
	:		30. Name and address of person will		leath /Itom (	23a) /Tuna		0.0	1000		1.10	Jus.	
	61		J Postor	North	1 Wes	4 11	osporta	1 (	ente	r Rar	idal	Istown	Maryland
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	re	2-1-100	1		1			1
	Registr	ar	AUG 10	2009 Den	m	1.	backer						
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State of Maryland / Department of Health and Mental Hygiene

**Physician** /Medical Examiner **Funeral** Director filed within 72 hours after death with the Maryland 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If a Modical Experiment for most by motified at Completed by Funeral Director Baltimore, Maryland 21215-0036 Be Department of Healt Important: If item 2; any Injury or other i **Physician** /Medical Examiner

anding physician and use as the burial-transit

P.O. Box 68760

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has to letely filled in by the funeral director, page 2 s To the within 2

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mugust 07,2009 ear 11:00A.M Margaret Marie Renz 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Pickersgill Retirement Community TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 17, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 1 □ M 2 1 F 90 213-16-9239 Chicago, Ill. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 ☐ Yes 21 No Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 615 Chestnut Ave. 21204 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3₺ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Hone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor A. Ryan Marie Margaret Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 13909 Fox Land Road Phoenix, Maryland 21131 Mrs. Kathleen R. Mohre 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
EVans Funeral Chapel August 08, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2009 22. Name and Address of Facility Peaceful Alfernatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093, P.A. 21. Signature of Funeral Service License 23a. Part I. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in fail. V. List only one cause on each line. Approximate Interval Between Onset and Death 20years Immediate Cause (Final disease or condition resulting in death) Vascular Disease Due to (or as a consequence of) 20years Cardiac Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) g □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hother (Specify) ASSIST. Liv. 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 🖺 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 El Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check.capty 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) August 07, 2009 R086954 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paula Kowalewski GBMC Towson Geriatric Services 6501 N. Charles St. Towson, MD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State backer Registrar AUG 10

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nea Ozelle Ku		State of Maryland / 1- For State Registrar	Certificate of D			. No. 200	9 2538
Physic Medical Exam		Decedent's Name (First, Middle Last)			2. Date of Death Month [ August 6, 2		3. Time of Death 2315 hrs
nodical Exam	11101	4a. Facility Name (if not institution, give street and number)	4b. (	City, Town, or Location of Deat		4c. County of Death	
		15309 Diamond Cove Terrace #A		ockville		Montgomery	
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 M		Under 1 Year If Under 24Hr Months Days Hours Mi		(MM/DD/YYYY) 9. Birt Foreig Con	
any		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
* *	tor	Maryland Montgomery		Rockvill			1 Yes 2 No
hours after death with the Maryland inatural", or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	15309 Diamond Cove	Unit 2 10 Terrace	f. Zip Code 20850	10g	. Citizen of What Cour	stry?
death with	unera	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2	If Yes, s	ecedent of Hispanic Origin? ( Specify Cuban, Mexican, Puert		14. Race - Ameri White, etc.	can Indian, Black,
s after rral", o	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes			Specify: B/	rck_
6	eted	15. Decedent's Education (Specify only highest grade com  Elementary/Secondary (0-12)  College (1-4 or 5	during most o	Isual Occupation (Give kind of of working life. DO NOT use re		Federal F	ndustry Assev
5-0036 led within 7' tygiene. other than	Completed	12	Trus	- Fund Ana	dyst	5	ystem
21215-0036 should be filed within 7 and Mental Hygiene. is marked other than atic event, the Medica	Be Co	17. Father's Name (First, Middle, Last) Frank Ruth		18.Mother's Nam	e (First, Middle, Ma Ellen F	1.4	
O동료·호	2	19a. Informant's Name/Relationship (Type, Print ) Frank Ruth		chocolate Cil	Rural Route Numb	er, City or Town, State	Lip Code) or 91
ore, ME es I and 2 s of Health a If item 27 her traum		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta	20b. Place of Disposition crematory or other p		Date	20c. Location - City or	Town, State
	1	4 Donation 5 Other Specify:	St. John	Cemetery 8	15/04	rineland	, S. Carolina
		21. Signature of Funeral Service Licenses	3572	and Address of Micility Par Frederick Av	Ker Fune re, Balti	nore, Mar	yland
Physician /Medical		23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.					Approximate Interval Between Onset and Death
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Box 687 he death certifice the attending place is the	sician/	past 12 months?	ime of death	(Specify)		WORTH L	Day Year
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Tospita Tospita Tospita Tospita		29a. Certifier		4 the time date and law	Terrace	#A Rockvil	.le, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	(Check only one)  1 Certifying Physician: To the best of my Medical Examiner: On the basis of examined and manner stated.					
	Σ	29b Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mor	nth, Day, Year)
	-	30. Name and address of person who completed cause of de	ath (Item 23a)	U.U.IVI.E.		August 7, 2009 —————	
			,	1 Penn Street, Baltimo	re, MD 21201		
St Regist	ate	31. Date filed (Month, Day, Year)  32. Registrar	s Signature	1			
	115	TOTAL SERVICE SERVICES	The same of the same of				

Sherry Lynn Rob	1	- For State	ate of N	/larylan	d / Dep <i>Ce</i>	artmen ertificate			and	Menta	al Hyg		g. No.	ni	19 2538
Physicia Medical Examin	n/	Registrar  1. Decedent's Name (First, Midd										Date of Deat	h Dav Yea	г	3. Time of Death 1945 hrs
Wedical Examin		SHERRY LYNN  4a. Facility Name (if not institution			er)		14	b. City, To	vn, or Lo	ocation of		August 6,	4c. County of	of Death	
		211 Courtland Place	, 3		,			Bel Air					Harford		
Funeral Director		5. Social Security Number	6. Sex	- 1	Age (In yrs.	last birthda	ıy)	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.		· ·	Foreig	rthplace (State or grWASHINGTON
Director		220-80-6385	1 M	2 X F		46	Yrs.					09/27	/1962	- 00	DC.
any		Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or I	ocatio	on							10d. Inside City Limits
	۲	MARYLAND HA	RFORD	СО					BELA	AIR					1 Yes 2 X No
Aaryla	Director	10e. Street and Number			1			10f. Zip C				1	Og. Citizen of WI	nat Cou	intry?
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.			orced If Yes	Yes s, Give Year	2 X No		1	Yes 2X	No	specify:			Specify:	WH	ITE ·
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of He		1 Burial 2 X Cremation	n 3 R	emoval from		crematory			or cem	etery,		Date	20C. LOCATION	- City 0	Town, State
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Division ral or Attendin rs after death.	Certification:		ld not be ermined	(Specify)		nd at		_	011100 00	anding, ou			State) 211 C		tland Place
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A		29a. Certifier 1 Certifying I	hysician:	To the best of	of my knowle	edge, death	occui	red at the t	ime, dat	te and pla	ice, and o	due to the cau	se(s) and manne and place, and	er as sta	ated. the cause(s)
To t	Medical	29b. Signature and title of certif	and	manner sta	ted.					number					fonth, Day, Year)
		( M	).						O.C.N				August 7,	•	
		30. Name and address of person	n who comp	leted cause	of death (Ite	em 23a)	_		_						
$\Psi$	10	Donna M. Vincenti, N	ID Ass	sistant Me	edical Ex	aminer	111	Penn S	street,	Baltimo	ore, MD	21201			, , , , , , , , , , , , , , , , , , ,
St Regist	ate	31. Date files (Month, Day Year		32. Reg	istrar's Sign	ature	مدي	,							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** August 6, 2009 1930 P M Adelbert Leon Suwalsky, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1**☑** M 2□ F 76 515-28-7611 **Director** March 29, 1933 Kansas Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Marical Extrainst must be notified at any injury or any at the strainst to notified at 1 ☐ Yes 2 🕅 No Director Maryland Rockville Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11325 Marcliff Road 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛛 No Specify: Specify: Š White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Tax Attorney Private Law Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adelbert Leon Suwalsky Elizabeth Constance Annis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11325 Marcliff Road, Rockville, Maryland 20852 Joan Suwalsky/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc August 10, 2009 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 M01548 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🙀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🙀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗆 Homicide

P.O. Box 68760 Records. Vital

Baltimore, Maryland 21215-0036

Hospital or Attending Physician:

Division of

State Registrar

Medical

29a, Certifier

(Check only one)

31. Date filed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

MA 066300

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

August 7, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 Sujoy G. Tagore, M.D.

and manner stated.



24 hours after death e Funeral Director:

within 2

			101	ertment of Health and Mertificate of Death		ene 3. No. 2009	25385
			Decedent's Name (First, Middle, Last)	Timedia a. Badiii	2. Date of Death		3. Time of Death
	Physici /Medic		Susan Lynn Sauntry		Month August 6	Day Year 5 2009	7:15 PM
and a	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
1			Suburban Hospital	Bethesda		Montgomery	
l.	Funeral Director		5. Social Security Number  148-22-6992  6. Sex 1 □ M 2 ☒ F  7. Age (In yrs. last birthda) 66 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y May 7, 19	ye <i>ar)</i> 9. Birth 943 Mai	
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	Mary -f sho	to	Maryland Montgomery Kensing	ton			1 □Yes 2 <b>X</b> No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cour	ntry?
	th with		3618 Littledale Road	20895	Ur	nited State	es.
036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Eventhearmust be redified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever In U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto for the Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	within 72 ho ene. than "natur he Medical I	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of workir DO NOT use retired) Attorney		Sb. Kind of Business/Ind	dustry
g 5	Hygi Hygi ther	ပို	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma		
au	id be lental ked o	To Be	William Joseph Schaefer	Emily Gu		,	
ary	shou and M s mar umat	-		ling Address (Street and Number or Rura		City or Town, State, Zip	Code)
Σ	and 2 salth a n 27 is		Mary Katherine Sauntry/Daughter 103	Timberbrook Ln. #10	01 Gaithe	ersburg, MI	20878
altimore,	Pages 1.			ematory or other place) Augus	t 9,	oc. Location - City or To Bethesda,	M 1 1
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		21. Signatur A Funeral Service I censee	m, Inc. 2019 22. Name and Address of FacilityRober hevy Chase, Inc. 7557 W	t A. Pumph Visconsin A	rey Funeral H Evenue Betheso	lome/Bethesda- da, ar land 20814
Г			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition Alcoholic Cirrho	sis			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
	Laminer	ē	Sequentially list conditions, if any, leading to immediate b. Breast Cancer  Due to (or as a consequence of):				
	nsit	Examine	Cause (Disease or injury				
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58760,	ficate be executed physician and s the burial-transit	dical	d. Altered Mental S	tatus			
. Box	death certi e attending d for use a	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive	ery Day Year
ds, F.	requires that the seen signed by th hould be detache	ρ	Part II. Other significant conditions contributing to death but not resulting in the ${\tt Duodenal\ Ulcer}$	underlying cause given in Part I.		cco use contribute to tl 2 🛣 No 3 🗆 Prot	
Sec.	e la has	Completed	Gastric Ulcer		24a. Was an autopsy periorme	prior to co	psy findings available mpletion of cause of
	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death	1.00	ZINO   TILI TES	2 LIN0
=	를 를 <mark>하</mark>	2	1X Yes 2 □ No Hospital: 1X Inpatient 2 □ ER/Outpatie	ent 3 ☐ DOA Other: 4 ☐ Nursing Hon	ne 5 Residenc	ce 6 ☐ Other (Specif	(y)
noi	ending Physician: ath. r: After this certifica he funeral director, p		27. Manner of Death  1 M Natural  28a. Date of Injury (Month, Day, Year)  28b. Time Injury  28b. Time	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
DIVISION	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funera	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office 2	28f. Location (Stree City or Town, S	et and Number or Rura State)	al Route Number,
	ne Hospii n 24 hour ne Funer	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or and manner stated.	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	and due to the cau ed at the time, date	use(s) and manner as s e and place, and due to	stated. the cause(s)
	To the training of training of the training of tra	Σ	29b. Signature and title of pertifier	29c. License number	29d	d. Date signed (Month,	Day, Year)
				D53691	A	ugust 7, 2	009
			30. Name and address of person who completed cause of death (Item 23a) (Type		1 100	050	
	Sta	te	Ajay Reddy M.D., 3200 Tower Oaks B 31. Date filed (Month, Day, Year) 32 Registrar's Signature		yıand 20	1034	
	Registr		AUG 1 0 2009 Cetura B. B.	extel			

DHMH 17 Rev 1/2001

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sale"			5. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday)	BALTIMORE CIT	8. Date of Birth	N/A	place (State or Foreign				
L	Funeral Director		214-24-1857 1 M 2M F 8		Months Days Hours Min.	12/16/192	Coi	MD				
	show			City, Town or Lo	cation			10d. Inside City Limits				
	he Mar 28a-f sl	ector	MD BALTIMORE RE	STERST		105	Citizen of What Cou	1 □ Yes 2 No				
	th with 1	al Dir	11708 TERRYTOWN DRIVE		10f, Zip Code 21136	Tog.	USA	mury r				
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If the firm 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the "Actical Example", until to puffical at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes, Give Year or Dates:	'	Nas Decedent of Hispanic Origin? (SpifYes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:					
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land	should be filed within nd Mental Hygiene. marked other than imatic event, n. M.	To Be	17. Father's Name (First, Middle, Last) LOUIS BAYLIN		18. Mother's Name	(First, Middle, Maio A	· ·	RFARB				
Maryland	12 should by and Men Y Is marke	[	19a. Informant's Name/Relationship (Type. Print) WILLIAM SIEGEL/HUSBAND	1	g Address (Street and Number or Rura	,		, ,				
	ss 1 and 2 of Health item 27 I		20a. Method of Disposition 20b.	Di LO:	B TERRYTOWN DRIVE,		Location - City or T					
Baltimore,	permit. Pages 1 a Department of Hee Important: If item any Injury or othe		1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	RCLE CI	Strong (Name of Access of	/2009 R0	SEDALE, MD					
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	To th withir To th comp	Me	29b. Signature and title of certifier  ABBS		29c. License number RES ~ 000	i i	Date signed (Month					
			30. Name and address of person who completed cause of death (Ite	m 23a) (Type, F	AH HOSPITAL OF	BALTI	MORE					
	Sta Registr	te ar	30. Name and address of person who completed cause of death (Ite RAJEEV GUPTA MISBS 31. Date filed (Month, Day, Year) AUG 1. 0 2009  AUG 1. 0 2009	ature par	L)							

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	Funeral Director		5. Social Security Number 6. S 229-18-0435	ex 7. Age (In yrs	8 Yrs.	Months Days		Irs. 8. Date of Birtle lin. Month, Day	Year)	9. Birthplace (State or Foreign Country) VIKOSA
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Ba-f sh	ctor	MD		Ba	Utimo	re			1 Pres 2 No
	3a or 2	i Dire	39/1 Shani	non Driv	e	10f. Zip Code	213		10g. Citizen of	What Country? USA
	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or items 23a or 28a-f show that than "natural", or items to notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in t Armed Forces?		Was Decedent of H	lispanic Origin? ar, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Ra Bla	ce - American Indian, ack, White, etc.
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	es 1 and of Health f itam 27 r other ti		TRANK WINE	20b.	Place of Dispo	esition (Name of matory or other place	*	Date		- City or Town, State
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ono	ding P th. : After t funera		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo	yat rk? Yes 2 ∐No	28d. Describe h	ow injury occu	irred
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3	V		30. Name and address of person who	completed cause of death (Ite	т 23а) (Туре,	Print) 200	יש לדי	BAUTIM	212 2	STREET
	V Sta	te	31. Date filed (Moeth, Day, Year)	32. Begistrar's Sign	nature	157	WIIMDI	reser riv	01000	<u></u>
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and	M		Usual Residence of Decedent  10a, State 10b. County	10c, City	, Town or Loc	ation				11	Od. Inside City Limits
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U Z I Z I 3-0030	erms	Funeral Director	11. Marital Status	<ol><li>Was Decedent Ever in U.S Armed Forces? /</li></ol>	3. 13. W	as Decedent of H	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	14. Race - Americ Black, White,	
s afte	or it	by Fi	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 Mo If Yes, Give		□Yes 212No	Specify:			Specify: R /	ACK
S John	atural Est Es	ed	15. Decedent's Educa	Year or Dates:	16a. Decede	ent's Usual Occur	oation		16b. K	ind of Business/In	dustry
<b>7</b> in 12	e. an "na Medir	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. D	ind of work done O NOT use retire	during most of wo d)	orking	,	/ -	
A with	giene er the	E O	6 th	College (1-401 04)	(ERT	FICO 1	JUPSIN	<del></del>		ONE FOR	THE HGED
be file	Mental Hyg arked other atic event,	Be	17. Father's Name (First, Middle, Last)	,				me (First, Middle	e, Maiden	Surname)	
al yld	l Men narke	၉	Calvel Powell	Win have			BEATR				7. = 04
<b>≅</b> ⊲	th and 7 is ma		19a. Informant's Name/Relationship (Typ	e. Print) / PODYN D	19b. Mailing	Address (Street	11-000	21. J. C.	ber, City o	1	Code) 21704
1 and	Health tem 27 other tr		20a. Method of Disposition	20b. P	ace of Dispos	ition (Name of atory or other place	1 -931	Date Date	20c. Lo	ocation - City or To	Town Md.
Pages	ent of nt: If it y or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			atory or other place	Ce) Aug 8	2009		EDERICK	MAA
Dermit. F			21. Signature of Funeral Service Licenses			Name and Addre	ess of Facility	,			MR NOME
ě	Depar Impor any ir		Dong J. Kon	Cles:	//	10 W. S				1. 2179	
	10		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death	. Do not ente	r the mode of dyir	ng, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
Pr	nysician		Immediate Cause (Final disease or condition	Intracrania	al hen	normhaga	L				Onset and Death
	Medical kaminer		resulting in death)	Due to (or as a consequ		1					-
	kannie	<u></u>	Sequentially list conditions, b.	Due to lor so a cones to	ones of						
ted	nsit	Examiner	Sequentially list conditions, if any heart cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse ju	ence orp						
execu	n and al-tra	Exal	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):		·				
cate be executed	physician and s the burial-transit	dical	d.								
	ng phi as th	fedi	TE SERVICE								
5 E	attending p	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnal		Ectopic pregnanc	CV		- 4	23d. Date of deliv	
e de	the at	Sici	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time of do 9 ☐ Unknown	eath 5	Other (specify) _				Month	Day Year
hat th	been signed by the should be detached	Phy	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the und	derlying cause giv	en in Part I	23e. Did	tobacco i	use contribute to t	he cause of death?
equires t	signe d be (	d by	Hypertension		and an are con-	sonying dados giv					bably 4 ☐ Unknown
S led	been	ete						24a. Was	e an	24h Were sut	opsy findings available
he la	e has	Completed	-					auto	psy ormed?	prior to co death?	empletion of cause of
an:⊥	certificate rector, pag	a	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only	2 No	1 ☐ Yes	2 □No
ysici	is certificate ha director, page	To B	examiner?	ospital: Inpatient 2 🗆 I	ER/Outpatient	3 □ DOA Oth	or:			6 □Other (Speci	fy)
Б	fter th neral		27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injui Wor		28d. Describe			-
tendin	eath. or: A the fu	catio	2 Accident investigation				lYes 2□No				
or Ati	fter d <b>Virect</b> in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stree ')	et, factory, office		28f. Location City or To	(Street ar wn, State	nd Number or Run e)	al Route Number,
pital	eral C		29a. Certifier 1 Certifying Physi	leise: To the hest of my know	vladao doath	occurred at the ti	mo date and place	and due to th	0.021160/6	and manner as	boteta
To the Hospital or Attending Physician: The law requires that the death certifications are suppressed to the Hospital or Attending Physician:	within 24 hours after death.  To the Funeral Director; After th completely filled in by the funeral	Medical		ician: To the best of my knower: On the basis of examinat and manner stated.							
o the	within Fo the sompl	Me	29b. Signature and title of certifier	,		29c. Licens	se number		29d. Da	te signed (Month,	Day, Year)
<b>)</b>			> fushlesa	MD		D67	7657			07/30/	2009
•			30. Name and address of person who con	npleted cause of death (Item	23a) (Type, P						
			FREDERICK NEW		400	w. 14h	27.	HED.	10	2170	/
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure	,					
	Registr	वा	ALIG 1 A PARA	Museum a.	Backe						

DHMH 17 Rev 1/2001

09-06074 John Richa

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			001	tificate of	Dealli		Red	g. No. 2 11	10 2522		
Physician	1	1. Decedent's Name (First, Middle,Last)					Date of Death     Month	2. Date of Death  Month  Day  Year			
edical Examine		John Richard Yates  4a. Facility Name (if not institution, give stre	4h City Town or I	ocation of Death	August 4, 2	4c. County of Deat	09 1142 Hrs				
		1800 Maryland Avenue & Wes		4b. City, Town, or Location of Death  Baltimore  4c. County of Death  None							
Funeral Director		5. Social Security Number 6. Sex 220–36–4567	7. Age (In yrs. la	ast birthday) Yrs	If Under 1 Year Months Days	If Under 24Hrs Hours Min	Familian				
1 e.		Usual Residence of Decedent 10a. State 10b. County  Maryland None		Town or Locati	ion				10d. Inside City Limits 1XX Yes 2 No		
the Maryland a or 28a-f show lifted at once.	niecto.	10e. Street and Number 2820 Maryland Avenue	2		10f. Zip Code	21218	, 10	g. Citizen of What Cou USA	Intry?		
er death with it, or items 23.	Luileiai	11. Marital Status  1 Never Married XX Married  3 Widowed 4 Divorced If Ye	Was Decedent Ever in U. Armed Forces?  Yes 2 V No	If Y	is Decedent of Hisp es, specify Cuban, Yes 2 No	Mexican, Puerto		14. Race - Amer White, etc.	White		
5-0036 ed within 72 hours after the within 72 hours after the wateral other than "natural" the Medical Ex mine.		15. Decedent's Education (Specify only high	ates:	16a. Deceden	nt's Usual Occupation ost of working life. I	on (Give kind of		16b. Kind of Business	/Industry		
5-0036 ed within 72 tygiene. other than 'the Medical		47 February (First Middle Lee)	5+	Pr	obation (		e (First, Middle, M	State (	of Maryland		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mernal Hygiene. Important! If item 27 is marked other than injury or other traumatic event, the Median To Re Commits.		17. Father's Name (First, Middle, Last)  Richard Dennis Yates  19a. Informant's Name/Relationship (Type,		19h Mailine		Eleano	or Miles	ber, City or Town, State	e Zin Code)		
MD 2 shou th and N n 27 is n aumatic	- 4	Ellen Sue Yates	Wife		,			re, Marylan			
ore, l	1	20a. Method of Disposition 1 Burial 2XX Cremation 3 R	1	Place of Dispos crematory or ot	sition (Name of cem her place)		Date	20c. Location - City o			
Baltimore, Department of Hee Important: If ite		4 Donation 5 Other Specify:	Gre	enMount	Cremato	ry 8/7	7/2009	Baltimore	, Maryland		
	21. Signature of Funeral Service Licensee  22. Name and Address of FarMatchell – Wiedefeld Funeral  6500 York Road Baltimore, Maryland 2  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  A										
Physician /Medical kaminer	ì	failure. List only one cause on each lin Immediate Cause (Final disease a. Mul	ie. tiple Injuries		ne mode or dying, s	such as cardiac (	or respiratory arre	st, snock, or neart	Approximate Interval Between Onset and Death		
	1	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.									
led bisit		if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated									
60, 00 at the property of the	200		ENDED								
the death certificate be executed by the attending physician and ched for use as the burial - traphysician and physician and phy	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of preg Live birth Pregnant at time of de	2 Fe	etal death 3	Ectopic pregn	ancy	23d. Date of delive Month	ry Day Year		
Box e death c the atten ed for us		1 Yes 2 No 9 Unknown g	Unknown	3 OI	ther (Specify)						
i, P.O.	<u>₹</u>	Part II. Other significant conditions cont	ributing to death but not r	esulting in the u	underlying cause gi	ven in Part I.		bacco use contribute to	o the cause of death?  obably 4  Unknown		
Cords law requi	andil						24a. Was a autops perform	sy prior to med? death?			
tal Rection: The certificate ector, page		25. Was case referred to medical			26.Place	of Death (Check	1 Yes 2	2 No 1 🗸 Y	/es 2 No		
f Vital Physician or this certi ral directo	2 L	examiner? 1 ✓ Yes 2 No	I inpatient 2	ER/Outpatient	o box			Residence 6 🗸 Oth	er: Scene		
Division of spiral or Attending Property and Property of the Property of Tilled in by the funeral Certification:	au011.	27. Manner of Death  1 Natural 5 Pending 2 ✓ Accident Investigation	28a. Date of Injury (Month, Day Year) Aug 4, 2009	28b. Time of 1 1142 hrs		y at Work? es 2 ✔ No		now injury occurred clist involved in n	notor vehicle		
Division spital or Attendia cours after death erat Director: Affilled in by the fi		3 Suicide 6 Could not be determined	28e. Place of Injury - At he (Specify) Local Street		et, factory, office bu	uilding, etc.	or Town, St	tate)	tural Route Number, City aFayette, Baltimore, M		
the the		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
F iv	29b. Signature and title of certifier 29c. License number 29d. Date signature										
	Theoder Me King Thymus D, O.C.M.E. DCME August 5, 2009										
12		30. Name and address of person who completed cause of death (flem 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
State Registra	<b>4</b>	31. Date filed (Month, Day, Year) AUG 10 2009	32 Registrar's Synati		/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - Registrar

Tor Amend Items 2, State of Maryland Benarines 65 Health and Mental Hygiene 2. Date of Death 06/30/2009 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 8:15 PM 0 ( Sa dams ce 2009 /Medical 4a. Facility Name (f not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death Examiner altimore 4venue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🗹 F Hours Months Min Davs 213-80-8568 Director Oct. 18, 196 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD altimore 28a-f death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 2121 USA Lyndell 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc 72 hours after 1 ∐Yes 2 Iv If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 PNo Specify: þ Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7½ th and Mental Hygiene. **7 is marked other than "ກ**ະ Elementary/Secondary (0-12) College (1-4or 5+) 10 None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leatrice ပ Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health ar Baltimore, MD. 21230
20c. Location City or Town, State Ave. 2148 eatrice Department of Heal Important; If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Cambridge, MD. augh Cemetery 22. Name and Address of Facility 11/09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee HENRY FUNERAL HOME, P.A., Slowashington St. Cambri MD.21613 by dge 23a. Patri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Un Know Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MI Examiner Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER unknown use as the burial-trans signed by the attending physician and Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Known Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes No
9 Unknown 3 Ectopic pregnancy page 2 should be detached for Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 2 certificate has 1 □Yes To the Hospital or Attending Physician; To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 X Yes Hospital: Other: 4 \( \sum \) Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manuer of Death 1 Natural Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 🗆 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

State Registrar 31. Date filed Month, Day,

TIMORE

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** July 27, 2009 4: 15 p M Kassa Alemayehu /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6214 Breezewood Ct. #303 Greenbelt Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08-19-1953 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**) M 2□ F Yrs Ethiopia 55 Director 212-85-3149 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event. The Wedical Examinar must be notified at 1X Yes 2 □ No Greenbelt Prince George's Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20770 6214 Breezewood Ct. #303 Ethiopia permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinat must pures. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerk Gas Station 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Zewde Mulusew Kebede Kassa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6214 Breezewood Ct. #303 Greenbelt, MD 20770 Teguaded Kebede (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burlai 2 □ Cremation 3 □ Removal from State Family Cemetery 08-03-09 4 Donation 5 ☐ Other (Specify) Ethiopia 22. Name and Address of Facility.H. Bacon Funeral Home, Inc. 3447 14th St. N.W. Washington DC 20010. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I mediate Cause (Final isease or condition resulting in death) HYPERTENSION Physician YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of Injury at Work? 1 Natural 5 Pending after death.

Director: Aft 1 🗆 Yes investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 1 🔛 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 8128200G /adem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 11120 NEW HAMPSHIRE AVE#407 SILVER SPRING MD 20904 TADESSE YARFD 31. Date filed (Month, Day, Year) 32. Registrar' Signat State 28 2009 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 31 Pay 2009 ear **Physician** JULY JAMES IRVING ALEXANDER, SR. 3:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Oueen Anne's Centreville Oueen Anne's 8. Date of Birth (Month, Day, Dec 25 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1⊠M 2□F 53 Delaware 212-66-1206 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at MD 1 XYes 2 □ No Kent Millington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or ? 32719 Cypress Rd. Apt. C 21651 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No þ 3 Widowed 4X Divorced Completed Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) r than the Me Elementary/Secondary (0-12) College (1-4or 5+) Excavation 12 Dozer Operator 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Franklin Alexander, Sr. Florence Estelle O'Neal ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Alexander (sister) 6209 Sudlersville Rd. Sudlersville, MD. 21668 Department of Health Important: If Item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/3/09 Smyrna, DE. Kent Cremation Service 4 Donation 5 Other (Specify) 21. Sign June of Funeral Service 22. Name and Address of Facility M00510

Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21

Partit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 611 CARcinon SOVAMORS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown \$ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed res 2 No page certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Hospice Home Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide n 24 hour⊾ the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

within 2. To the I

Jeffrey Ukens, M.D. 2540 Centreville Rd. 31. Date filed (Month, Day, 32. Registrar's Signature Year) State AUG 10 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of confifier

29c. License number

Centreville, MD. 21617

29d. Date signed (Month, Day, Year)

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Ronald Kenneth Byrd 10:25 PM 3 2009 Aug /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital
5. Social Security Number | 6. Sex | 7. Ade /In v Washington If Under 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1∏ M 2□ F Year) Min. Months Days Hours Yrs 16,1934 West Virginia 75 March Director 578-46-6480 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Md. Washington Smithsburg 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21783 U.S.A10831 White Hall Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes ≥ MNo If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 27 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White δ, 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Dealer Owner & Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Metcalf Emil M. Byrd ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1003 Lindsay Lane Hagerstown, Md. 21742 Roger L. Byrd (Son) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Aug. 6. Smithsburg, Md. Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. Je Por MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 ANIS First. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON **Physician** METASTIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Po in the past 12 months? 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No autopsy 1 ☐ Yes 2 Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenwithin 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar one)

KODUA H

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5

Th

MD

32. Registrar's Signature

324 E. ANTIETAM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PEPRAH

AUG 1 0 2009

29c, License number

0058181

ST. #306 HAGERSTONN

29d. Date signed (Month, Day, Year)

2009

AUGUST

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nn Cha	aries Bu	1	- For State	certifica	te of Deat			g. No.	000 252			
	Physicia	ın/	egistrar I. Decedent's Name (First, Middle,Last)				Date of Deat     Month	Day Year	3. Time of Death 0920 hrs			
ledical	Exami		JOHN CHARLES BURTON JR		14h City	Town, or Location of	July 26, 20	4c. County of D				
		•	ta. Facility Name (if not institution, give street and a 25551 Still Pond Neck Road	number)	Wort		Dean'	Kent				
F	uneral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Und			h (MM/DD/YYYY) 9	Birthplace (State or			
	irector		578-58-3412 1 X M 2 F	65	Yrs. Mont	ns Days Hours	Min. 11/12	/1943	oreignWashington Country) DC			
	any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
) }	show nce.	5	Maryland Kent	n			1 X Yes 2 No					
elveral.	th the Maryland 23a or 28a-f show any notified at once.		10e. Street and Number		10f. Zi	Code	1	10g. Citizen of What Country?				
4	3a or		25551 Still Pond Neck I	Rd.		21678	gin? ( Specify Yes or No	United States  Specify Yes or No- 14. Race - American Indian,				
4	ems 2	- T	4 Valour Married 2 Married Armed	Forces?	If Yes, spec	ent of Hispanic Ong ify Cuban, Mexican	, Puerto Rican, etc.)	White, etc.				
2	l', or it		3 Widowed 4 Divorced If Yes, Give Y	s 2 No Year	1 Yes	No specify:		Specify:	Black			
21215-0036	tural' amine	d by	15. Decedent's Education (Specify only highest g	rade completed) 16a. E	Decedent's Usua	Occupation (Give	kind of work done	16b. Kind of Busin				
<b></b>	/2 ho	leted	Elementary/Secondary (0-12) College	(1-4 or 5+)	uring most of w	orking life. DO NOT	use retired)					
003	er tha	omp	12 1	Me	ntal Di	sability	r's Name (First, Middle,	N/A Maiden Surname)				
15-(	Hyg d oth t, the	O	17. Father's Name (First, Middle, Last)				Louise Da					
21215-0036	uld be Mentz mark c even	0	John Robert Burton  19a. Informant's Name/Relationship (Type, Print )	19b	. Mailing Addres	s (Street and Nur	mber or Rural Route Nu	mber, City or Town,	State, Zip Code)			
Q ?	2 sho th and 27 is umati	[	Chantel Savage / Daugh	ter 14	6 42nd	Street NI	E Washingto	n, D.C. 2	0019 # G-41 ity or Town, State			
<u>ο</u> ΄.	Heal Fitem		20a. Method of Disposition  1 X Burial 2 Cremation 3 Remova		of Disposition (No ory or other plac		Date	20c. Location - Ci	ity or Town, State			
Baltimore, MD	permit. Pages I and 2 should be filed within 7.2 nours an Department of Health and Mental Hygiene. Importantt. If tiem 27 is marked other than "natural injury or other traumatic event, the Medical Examin		4 Donation 5 Other Specify	1	ny Memo	rial	8/4/2009	Landove	r, Maryland			
alti	epartu nport jury	1	21. Signature of Funeral Service Locusee	1101100	22. Name ar	d Address of Facili	Pope Funer	al Homes,	P.A.			
		_	23a. Part I. Enter the disease, or complications the failure. List only one cause on each line.	et caused the death. Do no	5538 M	arlboro 1	Pike Forest cardiac or respiratory ar	VILLE, Ma rest, shock, or heart	ryland 20747 Approximate Interval			
	ysician Medical		failure. List only one cause on each line.	tensive card	Howasa	lar dica	250		Between Onset and Death			
	aminer			as a consequence of):	IIUVASCI	ital uise	ase					
			Sequentially list conditions, b									
		Examiner	cause. Enter Underlying Cause	as a consequence of):								
	_ ;i	хап	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
	ecuted and - trans	اجاا	X AMENDED #1,23a,2/,perME, g894 8/21/09 TT									
,09	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transit	Medical	T- ON ENDED					23d. Date of de	elivery			
876	tificate ng phy as the	N/L	OOL Was decided assessed in the	es, outcome of pregnancy ve birth	Fetal dea	h 3 Ector	oic pregnancy	Month	Day Year			
Box 687	ath cer attendi	sicia	4 Pregnant at time of death 5 Other (Specify)									
<u> </u>	t the deatl by the att ached for	Physician/	Part II. Other significant conditions contributir		ig in the underly	ng cause given in F	Part I. 23e. Did	tobacco use contrib	ute to the cause of death?			
0.9	ires that th signed by I be detach	þ	l l l l l l l l l l l l l l l l l l l				1Y	es 2 No 3	Probably 4 V Unknown			
ds,	w require is been sign should b	Completed					24a. Wa		ere autopsy findings available for to completion of cause of			
Š	lawr hasb e 2 sh	ğ				·	per	formed? de	ath? ✓ Yes 2 No			
Division of Vital Records, P.O.	ysician: The l his certificate l director, page	ပိ	25. Was case referred to medical			26.Place of Deat	h (Check only one)					
/ita	hysician this cer Il directo	o Be	examiner? 1 ✓ Yes 2 No	Inpatient 2 ER/C	Outpatient 3	DOA Other	Nursing Home 5	Residence 6	Other: Scene			
of	ding Phy  After tl funeral	-	27. Manner of Death 28a. D	Date of Injury 28b.	Time of Injury	28c. Injury at Wo		e how injury occurre	d			
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is	or Al after d Direc I in by	Certification:	2 Accident Investigation 2 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural For Town, State)									
Ω	spital hours meral y filled		4 Homicide (Specify)  29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
	To To	Med	29b. Signature and title of certifier	ner stated.		29c. License numb	er	29d. Date signe	d (Month, Day, Year)			
			1 ( Inhorter	)		O.C.M.E.		July 27, 200	9			
5			3 Name and address of person who completed	cause of death (Item 23a)								
NZ				dical Examiner 11	11 Penn Stre	et, Baltimore,	MD 21201					
		tate	31. Date filed (Month, Pay Year) AUG 0 5 2009	2. Registrar's Signature	2							
	Regi		HUU U U LAGO CANONA	- 1. A.	DIOIN'A'							
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		For State Registrar	State of Ma	aryland / I		artment of H <i>rtificate of L</i>		/lental Hy	/giene Reg. No	2.0	09	25399	
Physicia /Medic		1. Decedent's Name (First, Midd Theresa	Rosaria			Barsa	_	2. Date of De		<b>Ю</b>	Year	3. Time of Death 11:26 A M	
Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or			4c. County of Death Anne Arundel		de1		
Irs a		House of Angels 5. Social Security Number 065-05-7817 6. Sex $1 \square \text{ M 2} \square        \text$			rthday) Yrs.	Crofton If Under 1 Year Months Days	8. Date of Bi	Birth		9. Birthplace (State or Foreign New York			
	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne	Arundel	10c. City, Tow Mille							11	0d. Inside City Limits 1 ☐ Yes 2√ No	
	Funeral Director	10e. Street and Number 871 Generals		10f. Zip Code 21108			_	tizen of W	hat Coun	try?			
	ρ	11. Marital Status  1 □ Never Married 2 □ Mar  WWidowed 4 □ Divorced	If Yes Give			Vas Decedent of Hi fYes, specify Cubai □Yes 2∏XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-		k, White, e	wan Indian, etc. White	
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)  Homemaker			ing	16b. Kind of Business/Industry  Own Home				
il Hygie other vent, it	Be Co	12 17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle	e, Maiden				
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and 2 sho salth and n 27 is me er traume		19a. Informant's Name/Relations Ken Barsa	hip (Type. Print) Son		871	g Address (Street a Generals	Highway	Miller	svill	le,MD	211	.08	
t. Pages 1 tment of H tant: If itel jury or otl		20a. Method of Disposition  1XX9urial 2 □ Cremation  4 □ Donation 5 □ Other (S	pecify)	Gate G	ry crem of H	sition (Name of patory or other place Leaven	7/21/	09		cation - Che	•	wn, State	
permit Depar Impor any in		21. Signature of Funeral Service	Licensee			Name and Addres	•	me P.A.	. 851 Gan	l Ann nbril	apol	is <sub>2</sub> R834	
Physician		23a. Part1. Enter to disease, or shock, or he rt failure. List Immediate Cause (Final disease or condition	complications that caused only one cause on each line	е.		er the mode of dying	, such as cardiac	or respiratory a	arrest,			Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as a	consequence	of)·	S MEL	1.1109	Typ	E 11	,			
ecuted and transit	Examiner	Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	CONSEQUENCE	эциенов об).								
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ital or Attending Physician: The law requires that the death certifus after death. ral Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 24 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal death		Ectopic pregnancy Other (specify)				23d. Date Mon		ery Day Year	
	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    DLD MYOCARDIAL TNFARCTION   23e. Did tobacco use contribute to the cause of deal   1   Yes 2   No 3   Probably 4   Young											
	Completed	ALZHEIMER					24a. Was			psy prior to completion of cause of death?			
	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 XNo	Hospital:			Othe	26. Place of Deat	h (Check only	one)			ASSISTED	
	ation: To	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	g 28a. Date of Injury (Month, Day)		Time of Injury	28c. Injury Work	at Nursing Ho	me 5 ∐ Res 28d. Describe		6 <b>X</b> Othe		y) Livinig	
	Certification:	4 ☐ Homicide building, etc. (Specify)							tion (Street and Number or Rural Route Number, or Town, State)				
	Medical	(Check only 2 Medical one)	g Physician: To the best of Examiner: On the basis of and manner stat	examination ar	e, death nd/or inv	estigation, in my op	inion, death occur	and due to the red at the time	, date and	d place, a	nd due to	the cause(s)	
		29b. Signature and title of certified	hand /ā	1	MI	29c. License		,		-		Day, Year)	
45	- 1	30. Name and address of person  RAY NO LD T	0	3100 3100	(Type, F	Print) RD BA	TIMOR	EDR.	<b>B</b> 110	BAL	Tiru	URL 21244	
Stat Registra	e ir	31. Date filed (Month, Julye 2	U 2009 22. Hegystral	s Signature		backer							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 July 23, **Physician** Marion Veronica Brooks 12:54 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year 10, 20, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Year) 1935 **Funeral** Months Days 1 □ M 2 🗷 F Rhode Island 036-22-9218 73 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County 'natural", or items 23a or 28a-f shov dical Evaminer must be notified at 1 ☐ Yes 2 No Director Maryland Wheaton Montgomery 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4118 Sampson Road 20906 USA Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married Married Specify: White 1 □Yes 2X No Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Food and Drug Elementary/Secondary (0-12) Health and Mental Hygiene. College (1-4or 5+) Program Analyst Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Fox Helen Uskovich 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) per nit. Pages 1 and 2 s
De artment of Health a
Important; If Item 27 is
any injury or other trau Victor Brooks, Jr./Husband 4118 Sampson Road, Wheaton, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 28 1 → Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Funeral Service Usensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rospitationy Failure **Physician** days disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) that the death certificate be Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown History of CV+ Completed Aiabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page perform LUNG (ancer 2 No 2 No 1 □ Yes 25. Was case ferred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examilier: 1⊠ Yes 2 □ No Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 124 hours after death. e Funeral Director: After t letely filled in by the funera 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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Baltimore, Maryland

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Division

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State Registrar 29a, Certifier

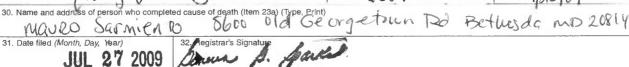
(Check only one)

29b. Signature and title of certifier

Mauro 31. Date filed (Month, Day, Year) Registrar's Signatur 27

and manner stated

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 17 per FH G894 8/12/09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Patricia Ione Burton 4:30A M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbur Coastal Hospice 9 Wicomico If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 67 Director 180-34**-**4688 03/21/1942 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 XNo Maryland Wicomico Salisbury 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21801 706 Upland Ct USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 🕱 No Specify. <u>Ş</u> white 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any injury or other traumatic event, the Mental once. Elementary/Secondary (0-12) College (1-4or 5+) administrative assistant university 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jessie Dean Taylor D.L. Norman 2 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) 706 Upland Ct., Salisbury, MD 21801 19a. Informant's Name/Relationship (Type. Print) Edward Burton/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 7/23/09 Donation Salisbury, MD Salisbury Crematory Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 4 at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause of each ine. Approximate Interval Between Onset and Death disease or condition resulting in death) **Physician** LUNG CARCINDMA LAHGNANT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the burial-transit and Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Y☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 autopsy performed? Yes 2/10 1 ☐ Yes 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \Backslash \) Nursing Home \( 5 \Backslash \) Residence Other (Specify) HOSPICA Medical Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of D ath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Ratural 5 Pending 1 ☐Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onli and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar

filed within 72 hours after death with the Maryland

21215-0036

Baltimore, Maryland

requires that the death certificate be executed

Hospital or Attending Physician: The

P.O.

Records.

Vital

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Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huram 31. Date filed (Month, Day, Year) Be Completed by Funeral Director

၉

Examiner

(Check only one)

29b. Signature and title of certific

**Physician** /Medical

**Examiner** 

**Funeral** 

**Director** 

		Certificate of Death	Reg. No.	2009 25398
Decedent's Name (First, Middle, Last)	D . 11-		2. Date of Death Month Day	3. Time of Death
HNN E.	BARKIBA	/- <sub> </sub>	107 22	09 1830 M
Eacility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Dear	th 4c. C	ounty of Death VICOMICO
Pannswa Kegiana Social Security Number 6. Sex	7. Age (In yrs. last birt	thday) If Under 1 Year If Under 24 Hrs		Birthplace (State or Foreign
17-30-9904 10	M 2□F 72	Yrs. Months Days Hours Min	(Month, Day, Year) 8-27-30	Country)
ual Residence of Decedent	100 City Tour	or Location		10d. Inside City Limits
a. State 10b. County	10c. City, Town	f.		1ÆYes 2 □ No
e. Street and Number	ico SAVI	10f, Zip Code	10g. Citiz	en of What Country?
008 Riverhouse	Do Ata	21801	1	USA
	2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (		1. Race - American Indian,
1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 No	If Yes, specify Cuban, Mexican, Puer  1 ☐ Yes 2 ☑ No Specify:		Black, White, etc.
3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			Specify: Black
15. Decedent's Educa (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)		d of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Domestic	1	JONE
. Father's Name (First, Middle, Last)	1		me (First, Middle, Maiden S	urname)
Norwood Cui	elis Se	RENAG	TER BE	ARKIEY
la. Informant's Name/Relationship (Typ	e. Print) / ( 19b	. Mailing Address (Street and Number or Fi	Tural Route Number, City or	Town, State, Zip Code)
UNDRA KOBERS	-DAUGHTER 18	13 N. DELAND AVE	5. SAISDURY	Mol 21801
a. Method of Disposition 1√Burial 2 □ Cremation 3 □ Re	cemeter	Disposition (Name of ry, crematory or other place)	Date 20c. Los	ation - City or Town, State
4□Donation 5□Other (Specify)	OREE		·25-09   Sali	soury, Ma
I. Signature of Funeral Service Licenses	tewart	22. Name and Address of Facility SEWAR FUNERA	Al Home 821	W. Road Salis, Ma
3a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do recause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between
nmediate Cause (Final sease or condition	metastatic	lung corcinama		Onset and Death
sulting in death)	Due to (or as a consequence of	of):		
equentially list conditions, b.	Don't form	-n.		
any, leading to immediate luse. Enter Underlying ause (Disease or injury	Due to (or as a consequence of	51).		
at initiated events c. sulting in death) Last	Due to (or as a consequence of	of):		
u.				
3b. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy	25	3d. Date of delivery
in the past 12 months? 1 □ Yes 2 ☑ No	4 Pregnant at time of death	5 Other (specify)		Month Day Year
9 Unknown			20 8:111	- Add Add Add Add Add Add Add Add Add Ad
rt II. Other significant conditions cont	ributing to death but not resulting in	n the underlying cause given in Part I.		e contribute to the cause of death?  No 3 Probably 4 Unknown
			Tigres 2	
			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			performed? 1 □ Yes 2 ☑ No	death? 1 ☐ Yes 2 ☐ No
examiner?	pspital:	Other:	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No Ho		tpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence 6	
	28a. Date of Injury 28b. 3	Other:		

29c. License number

DR

SHORE

D41721

SALISBURY mo

29d. Date signed (Month, Day, Year)

07,22 2009

21804

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical State Registrar

DHMH 17 Rev 1/2001

STEPHAN PANOS
31. Date filed (Month, Day, Year) JUL 2 4 2009

C

32. Registrar's Signature

400 €.

and manner stated.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Ared Prints 20bbc per FH I Lem 20 per FH I Lem State of Maryland / Department of Health and Mental Hygiene 25399 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey 2009 Month 07-**Physician** 21-3:22 a.m. Pearl L. Carmack /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street and number) Examiner Washington 13303 Fairfax Road Hagerstown If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 01-16-1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1□ M 2\\\XX Pennsylvania 77 177-24-5249 Director Usuel Residenca of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County PA Franklin 1 ☐ Yes 2 X No Hamilton Twp. Directo item 27 is marked other than "natural", or items 23s or 28s-1: other traumatic event, the Medical Examinar must be notifie 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 3296 Edenville Road USA 17201 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) A Hygiena. College (1-4or 5+) Elementery/Secondary (0-12) Textile Seamstress 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be is marked of Pages 1 and 2 should be nent of Health and Mentel Helen M. Brandt Robert C. Decker 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Depertment of Health a Important: If item 27 is any injury or other tra-3296 Edenville Road, Chambersburg, PA. 17201 (Husband) Vaughn Carmack 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a. Method of Disposition 1 
Burial 2 □ Cremation 3 □ Removal from State 7/25/09 Lincoln Cemetery Chambersburg PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas L. Geisel Funeral Home M01346 333 Falling Spring Rd., Chambersburg, PA 17202 23a. Part. Enter the discusse, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of Physician/Medical Examiner ettending physician and for use es the bunal-transit Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of): sate has been signed by the e paga 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown JONE Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 2 - No 1 ☐ Yes 2 ☐ No 1 ☐ Yes cartificate funeral diractor, 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother Specify her S Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of After residence Injury 1 Naturel 5 Pending To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: After completely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) edle ASS III

State Registrar

AUG 1

31. Dete filed (Month, Day, Year)

Certificate of Death

1 - For State Registrar

**Physician** 

1. Decedent's Name (First, Middle, Last)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

06

Reg. No. 2. Date of Death 3. Time of Death Month Year 200 4c. County of Death 9. Birthplace (State or Foreign Country) Dewar Year) 4 Oklahoma 10d. Inside City Limits 1 ☐ Yes 2/OXNo 10g. Citizen of What Country? United States 14. Race - American Indian. Black, White, etc Specify: White 16b. Kind of Business/Industry Aircraft 21901 20c. Location - City or Town, State North East, Maryland 127 South Main Street, North East, Maryland21901 Approximate Interval Between Onset and Death Unklain 23d. Date of delivery Dav Year 23e. Did tohacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 2 No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 261

Registrar DHMH 17 Rev 1/2001

State

Elkton

Street

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 21, **Physician** 2009 Harry Russell Conover 4:30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charlotte Hall St. Mary Charlotte Hall Veterans Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 ♣ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 174-18-2194 Pennsylvania 13, 1918 Director 91 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits r 28a-f show notified at 1X Yes 2 □ No Indian Head Marylans Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or must be r U.S.A. 33 Fairmont Place 20640 permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, Ite Madical Examiner must any injury or other traumatic event, Ite Madical Examiner must. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ∰es 2 Yes, Give 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □XNo ģ Specify: 3 X Widowed 4 □ Divorced Year or Dates: WWII White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Mechanical Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hoffman Lucy Conover ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1450, Marbury, Maryland Daughter Yvonne R. Grinder 20b. Place of Disposition (Name of cemetery, crematory or other place) July 24, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licen M00658 4270 Hawthorne Road, Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atrial **Physician** /Medical Due to (or as a sinsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 47N burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an cate has page 2 s certificate 1 □Yes 2 12 No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 12 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this ours after death.

neral Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Mann 1 Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely

State Registrar Signature a

FRANCISCA

31. Date filed (Month, Day, Year)

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CHARLOTTE

29c. License number

D67814

CHARLOTTE

29d. Date signed (Month, Day, Year)

20622

and manner stated.

29449

32. Registrar's Signature

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRUNEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Carrie A. Chester July /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town or Location of Death Examiner Vicamica Dalisbur Legional If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/13/1926 Funeral Months Days Hours Min. Country) 1 □ M 2 🗓 F 82 213-24-1601 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ∏Yes 2 No MD Wicomico Fruitland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 21826 USA 3701 Scott Lane - P.O. Box 114 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: à Black Specify: 3 X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Family 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Emma Victoria Black Henry Naaman Fountain 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irvin Chester/Son P.O. Box 114 - Fruitland, Maryland 21826 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/25/2009 4 □ Donation 5 □ Other (Specify) Green Acres Memorial Pk. Salisbury, MD 22. Name and Address of Facility Signature Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ena disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Tyes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident

be executed Box 68760, The law requires that the death certificate P.0. Division of Vital Records,

Director

show

ral", or items 23a or 28a-f shore Examiner must be notified at

"natural", or

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12 should be filed w h and Mental Hygie 7 is marked other th

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked i any injury or other traumatic ev

Physician

/Medical

Examiner

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attending p as

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s been signed b should be deta

has e 2 s

certificate

page

6 ☐ Could not be

determined

Whe

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

110

other traumatic event, if a Madical

hours after

within 72 h

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

Medical

State

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

completed cause of death (Item 23a) (Type, Print)

ulte

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760, dospital or Attending Physician: The law requires that the death certificate be executed

		For State	pe or Print State of Mary		Depa		f Health	and M	lental Hyg		nna	251.03
Physicia		1. Decedent's Name (First, Middle, Last)	l o o n						2. Date of Dear Month	th Day	Year 2009	3. Time of Death 20:55 PM
/Medic Examin		Kathleen De 1 4a. Facility Name (If not institution, give stre	eet and number)			4b. City, Town		of Death	July	4c. County of Death		
Funeral Director		Union Hospital of 6  5. Social Security Number  6. Sex  1  N	7. Age (	nty In yrs. last . 88	<i>birthd</i> ay) . Yrs.	Elkt If Under 1 Yes Months Day						place (State or Foreign of the first of the
faryland show sd at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Cecil	11	0c. City, To		Location 10d. Inside City					10d. Inside City Limits	
after death with the Maryland or items 23a or 28a-f show miner must be notified at		10e. Street and Number  163 Woods Way				10f. Zip Cod	e 921		1	Og. Citizen o		
ours after death with the Marylan ral", or items 23a or 28a-f show Examiner must be notified at	by		Was Decedent Ever Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	er in U.S.						pecity Yes or No- 14. Race - American		
ithin 72 hou ne. nan "natura Medical E	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)		11	(Give	lent's Usual Oc kind of work do OO NOT use rel	ne during mos	st of worki	ng	16b. Kind of	Business/In	dustry
I be filed wintal Hygier ed other the edother the	Be	17. Father's Name (First, Middle, Last)	6 Re 17. Father's Name (First, Middle, Last) Hobart R. Guthrie						Retail me (First, Middle, Maiden Surname)  I. Lawson			
nd 2 should alth and Me 27 is mark r traumation	To	19a. Informant's Name/Relationship (Type.  Carol L. Fisher / Da					eet and Numb	er or Rura	al Route Numbe	r, City or Tou		
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exagnee.		20a. Method of Disposition 1	noval from State			sition (Name of natory or other p	i	July 2009		20c. Locatio		own, State Maryland
permit. Departi Importi any inj		21. Signature of Funged Service Licensee			12	7 South	Main	Stree		h East		y1and21901
ate be executed // Medical Examiner fransit the burial-transit	lical Examiner	23å. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Cardial In far Chor.										Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown									Date of deliv	Pery M/A. Day Year
quires that I en signed by uld be deta	by	Part II. Other significant conditions contri	buting to death but r	not resultin	g in the ur	nderlying cause	given in Part	I.	23e. Did to	_		the cause of death?
The law recate has been	Completed								24a. Was a autop perfor 1 □Yes	sy		opsy findings available ompletion of cause of
sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	pital: 1 🗖 Inpatient	۵	(Outration	* 2 DOA	Other:		n (Check only or	/-	Other (Co.	26.3
nding Phy ath. r: After this ie funeral d	ation: To		28a. Date of Injury (Month, Day, )	28	b. Time of Injury	28c. [	njury at Nork? 1 □Yes 2 □		me 5 Resid			<u></u>
ital or Atters after de ral Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	(Specify)					City or Tow	n, State)		al Route Number,
the Hosp thin 24 hou the Funei mpletely fil	Medical	29a. Certifier (Check only one)		xamination		vestigation, in r	my opinion, de		red at the time,	date and plac	ce, and due	to the cause(s)
To with	4	29b. Signature and title of certifier  30. Name and address of person who com	SAMANT	,	PITAL	IST) D	6918			29d. Date sig	5 20	
5		TAN MAY SAMAN  31. Date filed (Month, Day, Year)		Bon	ST1	ZEET,	ELKT	014,	MD 2	1921		
Sta Registr		JUL 2.8.2009 A.	DZ. Hegistiai s		. 4.1	•						

25404

Physician	
/Medical	
Examiner	

**Funeral** 

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventual Teaching.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - State Registra/AMEND#24bperMD,7-29-09, BW, McCo Certificate of Death Reg. No.											
	1. Decedent's Name (First, Middle, Last)	_			2. Date of De	ath	Day Year	3. Time of [				
an al	MICHAEL ANTHONY DORSEY, SR.				July		, 2009		М			
er	4a. Facility Name (If not institution, give street and number)	4b. City,	Town, or Location	of Death		4	lc. County of Dea	ath				
	Holy Cross Hospital	- 11 11	lver Sp.	ring r 24 Hrs.	8 Date of Bir	th	Montgor	mery rthplace (State or	Foreign			
	214-58-2762 1™ 2□F 57 Y	Months		Min.	8. Date of Bir (Month, Date 11/28	3/5	1 MI	ountry)	roreigir			
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location						10d. Inside City	Limits			
ō	, , , , , , , , , , , , , , , , , , , ,							1 ޥes				
ect	MD Montgomery Pooles	10f. Zip	Code			10a (	Citizen of What C	country?				
al Dii	18610 Jerusalem Church Rd.		337			-	U.S.A.					
nel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic O	rigin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi					
Completed by Funeral Director	1 □ Never Married 2 Married 1 □ Yes 2 Maried 1 □ Yes 2 Married 1		□Yes 2⊠No Specify: Specify: Black									
oleted	15. Decedent's Education 16a. (Specify only highest grade completed)	Kind of Business	s/Industry									
Com	Elementary/Secondary (0-12) College (1-4or 5+)	ublic S	Schools									
Be (	17. Father's Name (First, Middle, Last)											
ပ	Joseph H. Dorsey, Jr. Mary Frances Lincoln											
	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0837											
	Tina Diane Dorsey wife 18610 Jerusalem Church Rd, Poolesville, MD  20a. Method of Disposition Date 20c. Location - City or Town, State											
	1 XBurial 2 ☐ Cremation 3 ☐ Removal from State? cemetery, crematory or other place)											
	4 □ Donation 5 □ Other (Specify)   Mt. 2								-			
	21. Signatur of Funeral Service Lice 22. Name and Address of Facility Snowden Funeral Home, P 246 N. Washington St, Rockville, MD 2											
	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mod	le of dying, such a	s cardiac o	or respiratory a	rrest,		Approximate Interval Betw Onset and D	reen			
	Immediate Cause (Final disease or condition Congestive he	a Congestive heart failure										
	resulting in death)  Due to (or as a consequence of											
Ļ.	Sequentially list conditions,  b. Acute renal failure											
nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
xan	Cause (Disease or injury that initiated events resulting in death) Last  C. Sepsis  Due to (or as a consequence of											
/Medical Examiner	d											
ledi												
an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic p	regnancy				23d. Date of de					
Be Completed by Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (sp					Month	Day Y	ear			
H-H	Part II. Other significant conditions contributing to death but not resulting in t	the underlying c	ause given in Part	I.	23e. Did 1	tobacc	o use contribute	to the cause of de	ath?			
q pe					10	Yes	2 □ No 3 □ F	Probably 4⊁ U	nknown			
plete					24a. Was		24b. Were a	utopsy findings a	vailable			
ШО			<del></del>		auto perfo 1 🗆 Yes	rmed	death?	completion of ca	use of			
Se C	25. Was case referred to medical		26. Plac	e of Death	(Check only o		10 10	LEMO				
ည	examiner? 1 ☐ Yes 2 ☒No Hospital: ☒☐ Inpatient 2 ☐ ER/Outr	patient 3 DC	OA Other: 4 □ N	lursing Hor	me 5 🗌 Resi	idence	6 □Other (Sp	ecify)				
Medical Certification: To	27. Manner of Death  ★ Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day, Year)	me of ury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		28d. Describe	how in	jury occurred					
rtifica	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory	, office	2		ocation (Street and Number or Rural Route Number, ity or Town, State)			er,			
al Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge,											
Medic	(Check only 2 Medical Examiner: On the basis of examination and and manner stated.			eatn occurr	ed at the time,							
	29b. Signature and title of cortifier	290	29c. License number 29d. Date signed					iui, Day, Tear)				
	30. Name and address of person who completed cause of death (Item 23a) (T	vpe, Print)	D65953				/17/09					
	Adaku Chimtua Onukogu, 1500 Forest Glen Rd, Silver Spring, MD 20910											

DHMH 17 Rev 1/2001

State

Registrar

27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician Mildred Bailey Dix 5:22 AM · 10 20-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salis bury Coastal Hospice at the Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕱 F 220-16-9401 83 Director 01/29/1926 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1 ☐ Yes 2 TNo Director Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 418 Valleywood Drive 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No <u>ک</u> Specify: white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lavman Bailey Beatrice Lusk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 418 Valleywood Dr., Salisbury, MD 21804 Orville Dix/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory
Gardens 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 Removal from State 5 ☐ Other (Specifi Donation 7/27/09 Hebron, MD Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Funeral Approximate Interval Between Onset and Death Enter the disease, or complication, that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one callse on each line. Immediate Cause (Final disease or condition resulting in death) & BROVASCULAR **Physician** ACCID BNT /Medical Due to (or as a consequence of): Examiner AILURR Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and burial-1 Due to (or as a consequence of): Box 68760, attending physiclan for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the a Ö 9 Unknown 9 Unknown <u>۵</u> 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 1 🗆 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 🗆 Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Martner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

State 31. Date filed (Month, Day, Year)
Registrar

HULAM

32. Registrar's Signature

BOX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

v

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink Frank Capies Are Legible.

		•	1 - For State Registrar	State of Mar	•	epartment of H Certificate of I			giene Reg. No.	2000	0 251.0
			Decedent's Name (First, Middle, Last	t)				2. Date of De	ath	Y	3. Time of Death
	Physicia /Medic		CHARLES T	HOMAS	EDEL	EN		Month JULY	Day	Year 2009	9:35 A M
-	Examin		4a. Facility Name (If not Institution, give	street and number)		4b. City, Town, or	Location of Death		4c.	County of Death	1
and the	Funeral		FREDERICK MEMO  5. Social Security Number 6. So		AL In yrs. last birth	FREDERI (	If Under 24 Hrs.	8. Date of Bir	th	REDERIC: 9. Birth	K hplace (State or Foreign untry)
ı	Director		213-76-7090	X м 2□ F Д	19 Y	rs. Months Days	Hours Min.	Sept. 15,	1959	)   Col	Maryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town	or Location			_		10d. Inside City Limits
	e Mar) la-f sh	ctor	Maryland Frede	cick	Knoxy	ville					1 □Yes 2MNo
	है के 9 28	Directo	10e. Street and Number		· ·	10f. Zip Code				zen of What Cou	-
	s 23a	eral	250 Knoxville Road			21758	in a sin O de le O (One	- i6 . V N -		nited St	
Maryland 21215-0036	urs after de al', or item Experiment	by Funeral	11. Marital Status  1 ☐ Never Married 2 ▼ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	Ispanic Origin? (Spe in, Mexican, Puerto Specify:	Rican, etc.)		14. Race - Amer Black, White Specify: Wh	, etc.
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Ext. Increment to Inflicatione.	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed) College (1-4or 5+)	16a.	Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	furing most of worki )	ng		nd of Business/I	
d 2	filed v Hygie other i	ပ္ပို	17. Father's Name (First, Middle, Last)			Truck Driv	er 18. Mother's Name	(First, Middle,			Delivery
an	ld be fental rked c	To Be	Everett Elwood 1	Edelen			Mildred	d Claud	ine .	Johns	
ary	shou and N s mai		19a. Informant's Name/Relationship (7	Type. Print)	19b.	Mailing Address (Street	and Number or Rura	al Route Numb	er, City o	r Town, State, Z	ip Code)
Σ	and 2 ealth n 27 i		Angela D. Weedon			) Knoxville		oxville	•		
ore	iges 1 nt of H : If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State		Disposition (Name of crematory or other place	i	Pate		cation - City or T	
Baltimore,	nit. Pa artmer ortant injury e.		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen		Smiths	ourg Cremato	ory July 2	23,2009			, Maryland
B	Dep Pep any onc	5 3	I M. IL		01473	Keeney and 106 E. Chi	l Basford Irch Stree	PA Fun	eral deri	Home,	vland 21701
	Physician <sup>®</sup>	85 19	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition		e death. Do no	ot enter the mode of dyin	g, such as cardiac o	or respiratory a	rrest,	,	Approximate Interval Between Onset and Death
and the	/Medical Examiner		resulting in death)	Due to (or as							1 (10
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence of	f):					
	cuted hd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С.							
90,	icate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of	f):					
68760,	ificate g physi	edical		.d							-
O. Box	The law requires that the death certificate be executed are has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at til 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	y		2	23d. Date of deli Month	ivery Day Year
rds, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death but r	not resulting in	the underlying cause give	en in Part I.			se contribute to	the cause of death? obably 4 N Unknown
Division of Vital Records,	The law recate has be page 2 sho	Completed		-				24a. Was autoj perfo 1 □ Yes		24b. Were au prior to death? 1 ∐Yes	topsy findings available completion of cause of 2 $\square$ No
Ĭ	sician; The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		nationt 3 🗆 DOA Othe	26. Place of Death				
ō	this ald	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Ti	me of 28c. Injur	4 LI Nursing Ho	me 5 Resi 28d. Describe			cify)
0	inding Path. r: After in funera	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Y	<i>(ear)</i> In		? Yes 2 □ No				
Divis	i 를 를 다	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, fari (Specify)	m, street, factory, office	l,	28f. Location ( City or To			iral Route Number,
	ne Hospital n 24 hours a ne Funeral I pletely filled	Medical	29a. Certifier (Check only one)  (Check only one)	ysician: To the best of a niner: On the basis of ea and manner state	xamination and	death occurred at the til dor investigation, in my o	ne, date and place, pinion, death occuri	and due to the red at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
h	To the within 2 To the complet	M	29b. Signature apartitly of certifier				6243		Ju1	y 18, 20	009
_			30. Name and address of person who of LAYEEN ROLF	completed cause of dear	th (Item 23a) (7	Fype, Print) TINLICE	FLENGI	LCE	MD.	-2170	4.
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 0 2	32. Registrar's	s signature	parkel					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State Registrar	tate of Maryland		artment of F			giene Reg. No.2 0 0 9	25407				
Physici /Medic		1. Decedent's Name (First, Middle, Last)  Brenda Edwina Fo	rd				2. Date of Dea	Day Yea	3. Time of Death				
Examin		4a. Facility Name (If not institution, give stree Washington County Ho			4b. City, Town, or Hagers	town		4c. County of De					
Funeral Director		5. Social Security Number  135-64-2988  Usual Residence of Decedent  6. Sex  1 □ M	7. Age (In yrs. las	48 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		v, Year) (	irthplace (State or Foreig Country) J				
72 hours after death with the Maryland natural", or items 23a or 28a-f show sicel Examinat must be notified at	Director	10a. State 10b. County MD Washington 10e. Street and Number	10c. City,	Town or Loc	cation 10f. Zip Code			10g. Citizen of What (	10d. Inside City Limits 1				
a or						•			Sountry?				
iges I and a Should be bried within 72 hours after death with the Maryla At of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination rulest to redified at	by Funeral	1 ☐ Never Married 2 🗓 Married	Vas Decedent Ever in U.S. Armed Forces? ☐Yes ②XXNo fYes. Give		2175 Vas Decedent of Hi fYes, specify Cuba  □Yes ※※ No		(Specify Yes or No- erto Rican, etc.)		nerican Indian, ite, etc. Thite				
z should be med within 7z hours after deal and Mental Hygiene. Is marked other than "natural", or items 'aumatic event, the Medical Examination in	Completed b	15. Decedent's Educatio (Specify only highest grade con	npleted)	lent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of v	vorking	16b. Kind of Busines	s/Industry					
r tha	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Waiti	ess			Resturant					
Mental Hygarked other	To Be C	17. Father's Name (First, Middle, Last) Unknown			18. Mother's Name (First, Middle, I Alice Forker			Maiden Surname)					
Ith and Ith and 27 is ma		19a. Informant's Name/Relationship (Type. F Alton D. Ford/Husbar	· 1		•		Rural Route Numbe	r, City or Town, State	Zip Code)				
Hea tem (		20a. Method of Disposition			sition (Name of natory or other place		Date	20c. Location - City of	r Town, State				
Department of Health as Important: If item 27 is any Injury or other trau		1 Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	var irom State	sant	Grove Ce	m. 07/		Warfordsbu	rg, PA				
Depar Impor any In		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368											
hysician /Medical xaminer		23a. Part1. Enter the disease, or complication shock, or heart failure. List the call immediate Cause (Final disease or condition resulting in death)	ons that caused the death. use on each line.  Due to (of as a consequer	OR.	er the mode of dyin	g, such as carc	liac or respiratory an	rest,	Approximate Interval Between Onset and Death				
physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Each U cettlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer										
he attending ied for use as	Physician/Medical	in the past 12 months?	i yes, outcome of pregnanc □ Live birth 2 □ Fetal de □ Pregnant at time of dea □ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)	1	23d. Date of d Month	23d. Date of delivery Month Day Year					
been signed by t should be detach	by	Part II. Other significant conditions contribu	ting to death but not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute to the cause of death?					
certificate has be rector, page 2 sho	Completed						24a. Was a autope perfor	sy prior to med? death?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
certific rector,	Be	25. Was case referred to medical examiner?	tal:	_	0.1		eath (Check only or	ne)					
h. After this funeral dir	n: To	27. Mann of Death	1 Linpatient 2 EH	NOutpatient Bb. Time of Injury	t 3 □ DOA Othe 28c. Injury Work	4 LI Nursino		ence 6 □ Other (Sp ow injury occurred	ecify)				
leat tor: the	Certification:	1	Be. Place of Injury - At home building, etc. (Specify)		M 1 🗆	r res 2□No	28f. Location (S City or Tow	itreet and Number or I n, State)	Rural Route Number,				
within 24 hours after o To the Funeral Direct completely filled in by	Medical (	(Check only 2 Medical Examiner:	n: To the best of my knowle On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin restigation, in my op	ne, date and pla pinion, death or	ace, and due to the occurred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)				
vithi To tl	Σ	29b. Signature and title of certifier	physi	car	29c. License			5th 28					
Sta	te	30. Name and dodess of person who completed the second sec	ated cause of death (lifem 20 and 12 and 13 and 13 and 14 and 15	3a) (Type, F	o Medic	CAI COM	naisRd.	Hugerst	oun Mos				

DHMH 17 Rev 1/2001

**ORIGINAL** 

3 )r

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** William Fletcher 9009 07 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Cambridge Dorches 8. Date of Birth (Month, Day, Year) MU) If Under 24 Hrs If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Exercities must be notified at 1 ☐ Yes 2 ☐ No Director ast OA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2160 ZI S A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑Never Married 2 ☐ Married 1 □Yes 2 No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Black

16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatin. Elementary/Secondary (0-12) College (1-4or 5+) None Never Worked 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dawson Goldie ပ aM Fletcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saundra Stone Mountain, Scy 3083
Date 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 7/27/09 4 Donation 5 ☐ Other (Specify) Glen Burnie, 23a: Party Enter the disease, or complications that caused the chath. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each lige. 21. Signature of Funeral Service Licensee Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of) Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed: After this certificate funeral director, page 1 □ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 ⊅tio 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 □ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760, requires that the death certificate be o σ, Records, Division of Vital To the Hospital or Attending Physician:

Maryland 21215-0036

Baltimore,

29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, State Registrar

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DONALD CARL FOWLER 200 ul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) May 19,1942 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral ½** M 2□ F Months Days Hours Min. 009-28-7133 67 **Director** Vermont Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Noticel Examination and injury or other traumatic event, Ite Noticel Examinations and injury or other traumatic event, Ite Noticel Examinations and injury or other traumatic event, Ite Noticel Examinations and injury or other traumatic event, Ite Noticel Examinations and injury or other traumatic event, Ite Noticel Examinations and Items 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 □XYes 2 □ No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12917 Yellow Jacket Road 21740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. rmed Forces? ☐Yes 2X No 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates: <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Model/Pattern Maker Department of Defense 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Charles Fowler Eleanor ၉ Rainev 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Fowler 12917 Yellow Jacket Road, Hagerstown, Md. 21740 Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Hagerstown Crematory |07-31-09 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility
Andrew K. Coffman Funeral Home, Inc.
40 Fast Antietam Street, Hagerstown, Md. 21740 21. Signature of Funeral Service Licensee -R. hoel Brad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arterio solerote disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown icate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? certificate 1 ☐ Yes 2 🗆 No 2 **⊡** No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 les 2 lo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No 24 hours after deatl Funeral Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 541-3 9.011 TU 140 31. Date filed (Month 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Year JÜĽŸ Cledis Earl Franks 11:45 AMM 28, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Reeder's Memorial Home Boonsboro Washington County 8. Date of Birth (Month, Day, Year)
March 30,1939 Tennessee If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months **™** M 2□ F Hours Min. 488**-**42**-**5071 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 253 Sunbrook Lane 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 N958If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give 1908 Year or Dates 1966 1 □Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Construction Extimator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Wayne Franks Agnes Florene Perry Franks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna R. Franks-wife 253 Sunbrook Lane Hagerstown, MD 21742 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of Rocky Gap Veterans Cemetery 1 🖾 Burial 2 🗆 Cremation 3 🗖 Removal from State 7-31-2009 Flintstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Kaetlin 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final رحب resulting in death) Due to (or as a consequence of):

**Physician** /Medical Examiner requires that the death certificate be executed

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once.

Baltimore,

ng physician ar as the burial-tr within 24 hours after death.

The Funeral Director: After this certific completely filled in by the funeral director.

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

		respection			7				
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):	~ ***						
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year						
Completed by Ph	~	ntributing to death but not resulting in the underly	ying cause given in Part I.		use contribute to the cause of death?  No 3 Probably 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4				
Be (	25. Was case referred to medical		26. Place of Death (Check only one)						
	examiner? 1 ☐ Yes 2 ☐ H	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Not Sing Home 5 ☐ Residence 6 ☐ Other (Specify)							
Medical Certification: To	27. Manner of Death 1 ☑ Hatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury N	28c. Injury at Work?	28d. Describe how inju					
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Stat	treet and Number or Rural Route Number, n, State)				
edical (	29a. Certifier (Check only one)  1								
Ž	29b. Signature and title of certifier		29c. License number	29d. Da	29d. Date signed (Month, Day, Year)				

D18015

28,2009

301-739-7100

State Registrar

VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

at mo

park

**ORIGINAL** 

within 2

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 1828 25 Ju1y **Physician** Fortune, Sr. Alfred H. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma Park Washington Adventist Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 8/26/1915 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Months Days Maryland 1 X M 2 □ F 93 579-38-4507 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 1 X Yes 2 No Hvattsville Maryland | Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20782 3105 Madison Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11 Marital Status 2□No1942-1 XYes 2 If Yes, Give Year or Dates: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 █ No Specify: 1945 δ 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Produce Supervisor 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lavinia Cooper William H. Fortune 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3105 Madison Place, Hyattsville, MD E. Marie Waters - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 7/30/2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 20722 3401 Bladensburg Rd., Brentwood, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neurnon Due to (or as a consequence of): Denic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23d. Date of delivery Yea

**Physician** / /Medical Examiner

**Funeral** 

**Director** 

23a or 28a-f show

event, the Medical Examiner must be notified at

"natural", or items

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event.

death with the Maryland

attending physician and for use as the burial-tran cate has been signed by the page 2 should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

this certificate

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Completed

Be

Medical Certification: To

Physician; The law requires that the death certificate be executed

or Attending

To the Hospital or within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760

23b. Was decedent pregnant in the past 12 months? 1 ∏Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

1 Tes 2√ No

27. Manner of Death

Natural

3 ☐ Suicide 4 Homicide

29a, Certifier

2 Accident

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown

28a. Date of Injury (Month, Day, Year)

3 Ectopic pregnancy 5 ☐ Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death? 1.☑Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performe 2X No 1 ☐ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month, Day,

5 Pending

investigation

6 ☐ Could not be determined

29c. License number 45660

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 7-26-09

30. Name and ordress of person who completed care and ath (Item 23a) (Type, Print) CALCA 3CC

Hospital:

0

1)☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

State Registrar



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For Amended item#10g, WCHD, SLU, 7.24.09

Registrar Registrar Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** PM Dorothy Marie

4a. Facility Name (If not institution, give street and number) tontaine 07 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner icomico the 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 84 Months Davs 1 ☐ M 2 🔀 F 220 - 26 - 1688 Usual Residence of Decedent Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must be reaffled at 1 ☐ Yes 2 No Director the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29659 2187 rmount Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Grandparent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be 1 Health and Mental Ames anue 19b. Mailing Address (Street and Number or Rural Route Number, City 19a. Informant's Name/Relationship (Type. Print) Shirley 29651 Mq. Snead daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Method of Disposition Pages ' 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4. M.C 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Signature of Funeral Service Licensee salistary Md. Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONCRSTIVE HEART PAILURE

Due to (or as a consequence of): Approxima Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner CUTA sque Itally list on altions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a □Yes 9 Unknown 9 Unknower 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably # Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 40 certificate 1 ☐Yes 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be LOSPICA Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) ဂ္ After this funeral ( 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0.0 BOX 2180 atturan WA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 4 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 6:50 P M AUGUST 2, 2009 GLASER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Days Hours 1 X M 2 □ F 14, 1963 119-58-4446 46 Feb. New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 ☐ No Frederick Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 United States 1808 Addison Court 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 Never Married 2 Married □Yes 2 No If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Maintenance Mechanic Machine Repair 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Bergquist Howard Glaser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1808 Addison Court, Frederick, Maryland 21701 Deborah R. Taylor / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition August 6, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funeral Service icensee No MO1473 106 E. Church Street, Frederick, MD 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Chest pain disease or condition resulting in death) Due to (or as a consequence of): incontrolled Cholisters incontrolled Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 🛣 No 1 ☐ Inpatient 2 ► ER/O 27. Manner of Death 28a. Date of Injury (Month, Day, Year)

Physician /Medical **Examiner** 

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It a Modical Examinar must be invitined at

and Mental Hygiene.

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau

should be fi and Mental H

Baltimore,

the Maryland

72 hours after death with

Physician: The law requires that the death certificate be executed and burial-trai attending physician the use jo the ģ signed t director, page 2 should been has this After t or Attending 24 hours after death Funeral Director: filled in by the

Division of Vital Records, P.O. Box 68760,

Hospital

within 2

					performed? death? 1 □ Yes 2 No 1 □ Yes 2 □ No					
			26.	Place of Dea	eath (Check only one)					
utpatient	3 🗆 1	DOA	Other: 4	☐ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)					
Time of Injury	М		Injury at Work? 1 □ Yes		28d. Describe how injury occurred					
arm, street, factory, office					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
e, death	occurr	ed at	the time, da	ate and place	ce, and due to the cause(s) and manner as stated.					

CRESTWOOD BLUD FREDERICK MD 21703

(Check only one)
20h Signature

1 Natural

2 Accident

4 - Homicide

3 Suicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

MD

BONNIE FITTLEBERG

5 ☐ Pending investigation

6 ☐ Could not be

1006520

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, f building, etc. (Specify)

MP

State Registrar 31. Date filed (Month, Day, Year) AUG 10

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State of Maryla		artment of Heal		20	ene g. No. 200	19 251.11	
			Decedent's Name (First, Middle, Last)				2. Date of Death		- 14 0 1 1	
	Physici	an	Sondrales Goldhamme				Month	Day Ye	3. Time of Death	
	/Medie			6-410			7 2	4 20	· · · · · · · · · · · · · · · · · · ·	
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locat			4c. County of I		
			702 Pilot House Drive		Annapo1			Anne A		
	Funeral		1 M 2 TYE	s. last birthday) Yrs.	If Under 1 Year If Un Months Days Hou	urs Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country) Lew York	
	Director		062 - 22 - 7009 74  Usual Residence of Decedent	110.		D	ec. 3,	1934 N	lew York	
	and and			City, Town or Lo	ncation				10d. Inside City Limits	
	laryl i sho	ō	Maryland   Anne Arundel		apolis				1 Yes 2 □ No	
	28a-	ect	10e. Street and Number	7 13 13 10	<u> </u>					
	with a or	ä	702 Pilot House Drive		10f. Zip Code	1401		g. Citizen of What Country?		
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examirat must be redified at	Funeral Director						United S	tates	
	er de	Ë	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hispanio If Yes, specify Cuban, Mex	ic Origin? (Spec xican, Puerto R	cify Yes or No- ican, etc.)		American Indian, Vhite, etc.	
9	o, or	by F	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give Year or Dates:		1 □Yes 2 🔯 No Spe	ecify:			white	
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215-0036	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of working	g   10	6b. Kind of Busin	ess/Industry	
7	within ene. <b>than</b>	Ę	Elementary/Secondary (0-12) College (1-4or 5+)	Hor	nemaker			Own Hom	ne	
N	lled \	ပိ	12							
and	be find that He of ot ot	Be	17. Father's Name (First, Middle, Last)				First, Middle, Ma	aiden Surname)		
Š	I Me	၉	Herman Noier			Ray Jac				
Mar	2 sh n and ris n		19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and Nu					
<u> </u>	and lealth m 27 her t		Sharon Nussbaum, Daughter		Rising Wave	es way,	COLUMDI	a, MD Z	21044	
פב	Jes 1 t of F Mite or ot		20a. Method of Disposition 20b.  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, crer	sition (Name of natory or other place)	Da	te 20	0c. Location - City	y or Town, State	
Ę	Pag ment ant: ury o				norial Garde	ns 07/2	26/09	Olney,	MD	
Saltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examirat must be rediffied at once.		21. Signature of Funeral Service Licensee MOIOOS	2 <del>2</del> 2	Name and Address of Fa	acility Eu	inoval H	omo		
0	80 E 8 9		740000		54 Carroll S				20012	
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4	eath certifica attending pt for use as th	× ×	IF FEMALE: 23c. If yes, outcome of pregn	anov						
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9	ertific ctor,	Be (	25. Was case referred to medical examiner?		26. P	Place of Death (	Check only one)		163 2 1110	
	nysic dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 □	] ER/Outpatien	Othor:		- 1	ce 6 ☐ Other (	Specify)	
- 1	ter the neral	Ë	27. Manner of Death 28a. Date of Injury  1. Natural 5 Pending (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?		d. Describe how		Specify)	
2	ath.	atic	1. Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	Injury	M 1 ☐Yes 2	2 🗆 No				
2	er de	<u>i</u>	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	eet, factory, office	28	f. Location (Stre	et and Number o	r Rural Route Number,	
<u> </u>	s afte	Certification:	building, etc. (Special	(y)			City or Town,	State)		
1000			29a. Certifier 1 Certifying Physician: To the best of my know	owledge, death	occurred at the time, date	te and place, an	nd due to the cau	use(s) and manne	er as stated.	
1	n 24 n 24 <b>ne F</b> t	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or inv	vestigation, in my opinion,	death occurred	at the time, dat	e and place, and	due to the cause(s)	
15	Neithi Com th	ž	29b. Signature and title of certifier		29c. License numb	per	290	d. Date signed (M	onth, Day, Year)	
1	2_		DI XXXXX		D6527	.2	-	7/24/1	9	
•		-	30. Name and address of person who completed cause of death (Itel	m 23a) (Tvne 1						
			Days Tikes 900 Ber	1. 11	Del Su	1 3 al	Da.	vibrilis 1	40 21401	
	Stat	е	31. Date filed (Month, Day, Year) 32/Registrar's Signa	ature		. , C 0 V	Nil	11.61.1	18 1	
	Registra	_	JUL 27 2009 Deteur	9. Da	Med.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 state
Registrar AMEND#26perIMD8/4/09, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month CYNTHIA DAWN GIBSON 22 2009 July 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9110 Blues Alley, #B Howard Laurel Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Min. Hours 1 □ M 2 🖾 F 214-76-2374 39 Director MD 6/28/70 Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Eventher must be notified at 1 No 2 No Director MD Howard Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9346 Canterbury Riding 20723 Funeral U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ∐Yes 2√2 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Black Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Computer Specialist Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cornelius Gibson Department of Health and Ment important: If item 27 is marked any injury or other traumatic e Mary Matthews ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Gibson 9346 Canterbury Riding, Laurel, MD 20723 -Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St Maryland Natl. Mem. Pk 7/29/09 Laurel, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. uneral Service Li 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OUARIAN 7400B Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? known ailable se of e

Box 68760, P.0. Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Baltimore, Maryland 21215-0036

7	3		1 Yes 2 No 3 Probably 42 Uni
Completed			24a. Was an autopsy performed? 1 □ Yes 2 ⊠No 24b. Were autopsy findings av prior to completion of cau death? 1 □ Yes 2 □ No
To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	Check only one)  2nd Residence e 5
tion.	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
Cartific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	off. Location (Street and Number or Rural Route Number City or Town, State)
dical	29a. Certifier Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place, an inner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)

29b. Signatu

29c. License number 30929 29d. Datersigned (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, and 1865 ) Year) 31. Date filed (Month. Day. 2. Registrar's Sign

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	/ Depa	artment of I	Health an	d Mental Hy	giene	
			1 - State Registrar	Ce	rtificate of	Death		Reg. No.)	25117
	Physicia	20	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic		Mary Harvey					28, 2009	1:36A M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o			4c. County of Death	
made.	<b>-</b>		10604 Gay Place  5. Social Security Number 6. Sex 7. Age (In yrs. Ia	st hirthday)	Upper If Under 1 Year				Georges  pplace (State or Foreign
	Funeral Director		126-24-8907   1□M 2\\ F   8		Months Days	Hours N	Hrs. 8. Date of Birt (Month, Day Jan. 11	. 1921 N	intry)
			Usual Residence of Decedent					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	ırylan show	Ļ	10a. State 10b. County 10c. City,	Town or Lo	ocation				10d. Inside City Limits 1 ▼Yes 2 □ No
	Ba-f s	acto	MD PG	U	oper Ma	rlboro		10.00	
	with the	ä	10c. Street and Number		10f. Zip Code	277		10g. Citizen of What Cou	•
	eath v	Funeral Director	10604 Gay Place  11. Marital Status 12. Was Decedent Ever in U.S	13		0772	? (Specify Yes or No-	United S	
(0	ours after death with the Marylan ral", or items 23a or 28a-f show Evaminer must be notifled at	臣	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ▼No		If Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)	Black, White	
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Maryland	0 = 0 0	To Be	Henry McKinnon			Ida	White		
ary	2 should and Mer is marke aumatic	-	19a. Informant's Name/Relationship (Type. Print)	19b. Maili	ng Address (Street	and Number o	or Rural Route Numbe	er, City or Town, State, Z	ip Code)
	and 2 ealth a n 27 is		Henry Harvey/son	_Uppe	)4 Gay I er Marlk	oro.	Md. 2077	2	
Baltimore,	9 - L		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ice of Disponentery, crea	osition (Name of matory or other pla	ce)	Date	20c. Location - City or	own, State
Ë	t. Pag tmen tant: ijury		4 □ Donation 5 □ Other (Specify) Ceo					Middlehop	
Bal	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service Licensee					Edwards 1	
			23a. Par 1. Enter the disease, or complications that caused the death.					Suitland,	
	Dhusisian		/slock, or heart failure. List only one cause on each line. Immediate Cause (Final	Į,	1 /		1.		Approximate Interval Between Onset and Death
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687	ificate g phys	edical	d				2		
Box	death certif e attending id for use as	M/m	IF FEMALE: 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal					23d. Date of del	very
	deat ne atte ed for	Physician/Me	1 Yes 2 No 4 Pregnant at time of de		☐ Ectopic pregnan☐ Other (specify) _	Су		Month	Day Year
P.0	at the	Phy	9 Unknown	ita a ta Man		and in Book (	220 Did to	obacco use contribute to	the course of death?
JS,	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	þ	Part II. Other significant conditions contributing to death but not result	ing in the t	nderlying cause gr	ven in Part I.		Yes 2 □ No 3 □ Pr	1
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Rec	e fa has	dm	Congest Ve HTON TO 1100-	^	17079		24a. Was autop perfo	psy prior to o prmed? death?	topsy findings available completion of cause of
ta	ician: The certificate hirector, page		25. Was case referred to medical	19		26 Place of	1 ☐ Yes  Death (Check only o		2 D No
>	iding Physician: th. After this certifica funeral director, p	To Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3 □ DOA Oti	her-		dence 6 ☐ Other (Spe	cify)
סר	ig Phy ter thi neral	n:T	27. Manner of Death 28a. Date of Injury	28b. Time o		ıry at		how injury occurred	,,
Sior	Attendin death. ctor: Af y the fur	atic	2 Accident investigation	,,		Yes 2 □ No			
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, st	reet, factory, office		28f. Location (3 City or Tov	Street and Number or Ru wn, State)	ral Route Number,
	pital ours a eral D		29a. Certifier 1 Certifying Physician: To the best of my know	ledge dea	th occurred at the	time date and r	place, and due to the	cause(s) and manner as	stated
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical	(Check only one)  Medical Examiner: On the basis of examination and manner stated.	on and/or in	nvestigation, in my	opinion, death	occurred at the time,	date and place, and due	to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier		29c. Licen			29d. Date signed (Monti	
			> Web Calealura	>	000	3706	6	07-31-20	09
			30. Name and address of person who completed cause of death (Item	23a) (Type,	Print)	10 10	110143	07-31-20 El, Oton 11-	4/
النزر			Uthethi 7. Ofg 952094, M. 31. Date filed (Month, Day, Year) 32. Registrar's Signatu		18807	ロリス	11 14 7	U, U ton /	11,40
	Sta Registr		AUG 1 0 2009 Scheur	A.	backer				

5 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 28e, i per me, g899,01/11/10dhb Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05PM Day **Physician** Month Year 2009 Darbara Man /Medical 4a. Facility, Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Month, Day. Social Security Number 6. Sex Birthplace (State or Foreign Country)
 WV . Age (In yrs. last birthday)
57 Yrs. **Funeral** 1□M 2 F Months Days Yrs. 0970671951 279-52-7997 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar manner. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f shov imatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No WV Tucker Dry Fork 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Rural Route HC60 Box 19 26263 USA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Layne Hinkle, Jr. ဂ္ Anna May Harper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey K. Huffman/Husband HC60 Box 19 Dry Fork, WV 26263 Baltimore, 20b. Place of Disposition (Name of F 1 Americans germatory of ginar place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/05/2009 Red Creek, WV Cemetery 21. Signature of Funeral Service Licenses Hinkle Funeral Home, Inc. POBox 186 Davis, WV 26260 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Carlmo /Medical Due to (or as a consequence of): trauma Examiner Esquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events oc. Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the detached f 1 Tyes 2 PNo 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home Hospital: 1⊠Yes 2∐No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2009 within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 10:A investigation 1 ☐ Yes 2 Accident DICVOLF 3 ☐ Suicide 6 ☐ Could not be Pr-ce of Injury - At home, farm, street, factory office building, etc. (Specify) State Park 28f. Location (Street and Number or Fural Route Number, City or Town, State) Canaan Valley S Park, Canaan Valley, West VA determined 4 Homicide State 21 00 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certif 29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (ILL 23a) (Type, Print) Na

State Registrar

31. Date filed (Month, Day, Year)

AUG 1

DHMH 17 Rev 1/2001

**ORIGINAL** 

32. Registrar's Signature

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			For State Registrar	State o	of Maryl		partment <i>ertificate</i>			Mental H	ygiene Reg. Ne	00	ne	251.1	Q
4	Physicia	an	Decedent's Name (First, Middle     LEMUEL LAWRENCE							2. Date of I	Death	6, 20	ζġ	3. Time of Death 8:35 P M	1
>	/Medic Examin		4a. Facility Name (If not institution FORT WASHINGTON	, give street and nu					ocation of Dea	ıth	40	c. County of	f Death		
	Funeral Director		5. Social Security Number 218–24–6821	6. Sex 1 ★ M 2 ☐ F		yrs. last birthd Yrs	(ay) If Under		If Under 24 Hrs Hours Min	s. 8. Date of I	Birth Day, Year <b>18, 1</b>	1931 N	9. Birthpl Count MARYI	ace (State or Foreign	n
	W W		Usual Residence of Decedent  10a. State 10b. County		100.	. City, Town or	r Location						10	d. Inside City Limits	
<b>3-0030</b> 72 hours after death with the Maryland	un with the Mar 23a or 28a-f sh ust be notified	I Director	MARYLAND CHAI  10e. Street and Number  3115 POSEYTOWN		N	IANJEMO	10f. Zip	Code 0662			1 10g. Citizen of What Country? UNITED STATES				)
90	ges 1 and 2 should be filed within 72 hours after death with the maryis to f Health and Mental Hygiers. It of Health and Mental Hygiers is the fitten 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2 X No ive	in U.S.	13. Was Deced If Yes, spec	ity Cuban	panic Origin? ( , Mexican, Pue Specify:	Specify Yes or ento Rican, etc.)	No-	14. Race Black, Specify:	, White, e		
00-617	Imin 72 nou ne. nan "natura nadical E	Completed b	15. Deceden (Specify only highe. Elementary/Secondary (0-12) 7TH GRADE	ecedent's Usua ive kind of wor fe. DO NOT us	rk done du e retired)	uring most of w	orking	Ī	16b. Kind of Business/Industry  FEDERAL GOVERNMENT						
	z snould be liled within and Mental Hygiene. is marked other than " aumatic event, the Me	To Be Cor	17. Father's Name (First, Middle, LOUIS HEARD	Last)		ЬО	ILEK OF	· .	18. Mother's Na	ame (First, Midd (DOTSON)	lle, Maide	n Surname		2KW117W I	-
, K	es 1 and 2 should of Health and Men item 27 is marke cother traumatic	_	19a. Informant's Name/Relations IRETHA C. HEAR			311	5 POSEY	TOWN		Rural Route Nur	Y, M	ARYLA	ND	20662	
	rages 1 ment of H ant: If iter ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		State	cemetery,	isposition (Nam crematory or of CHURCH C	ther place		31, 2009	1	EMOY, I			
חשור	permit. Prag Department Important: I any injury o		21 Signature of Funeral Service	N JOHNSON	M00583		THORNTO 3439 LI	Address VING	NERAL I	HOME, P. DAD, INI	A. DIAN	HEAD,	MAR	YLAND 206	<b>4</b> 0
,00	Thysician physician and physician and physician and the pnual-transit the pnual-transit and the pnual-transit	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  SEPSIS  Due to (or as a consequence of):												
O. BOX 60	law requires man me deam cermicate as been signed by the attending phys 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									23d. Date of delivery Month Day			
US,	uires mat signed b d be deta	þ	arti. Other significant conditions contributing to death bache resoluting in the directlying educe given in rate.								23e. Did tobacco use contribute to the				'n
	0 1 0	Completed									24a. Was an autopsy performed? 1  Yes 2 No 24b. Were autopsy findings prior to completion of c death? 1  Yes 2 No 1  Yes 2  No				е
_ \ _ [	iysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hoopital:	] Inpatient	2 ☐ ER/Outpa	atient 3 D0	Otho	p.	eath <i>(Check on</i> Home 5 🗆 R		6 □Othe	er (Specify	<i>'</i> )	
	to the hospinal or Attending Priysician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: T	27. Mapner of Death  1 A Natural 2 Accident 3 Suicide 4 A Natural 5 Pendir investi 6 Could	gation not be 280 Plac	nth, Day Yea		ne of 2 Iry M		at ? ′es 2 □ No	28d. Describ				I Route Number,	
<u>ב</u>	ipiral or A		4 _ Hornoide	ng Physician: To th	ding, etc. (Sp		leath occurred	at the tim	e. date and pla		Tówn, Sta		nner as st	ated.	
	ro the hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical		Examiner: On the and mai			or investigation		oinion, death oc		ne, date a		and due to	the cause(s)	
	- 'A F 8		30. Name and address of person	10	ise of death	(Item 23a) /Ti			25/25	162	=	H2'	71	2009	_
1	06	ote		MAN, MD.,		LIVIN		ROAD,	FORT V	VASHINGT	ON,	MARYL	AND	20744	
DHM	Sta Registi	rar	JUL 27				parke				_				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Juil **Physician** 2004 Kathy Willey Hachemeister /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b. City, Town, or Location of Death Examiner ambrida 8. Date of Birth (Month, Day, June 23, If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1947 **Funeral** Days Hours 1 □ M 2 😾 F Maryland 62 216-48-6026 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Eventher must be notified at MD Dorchester Cambridge 1 ☐ Yes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Kathy Hachemely 21613 USA 15 Merryweather Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: white ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) county recreation Elementary/Secondary (0-12) College (1-4or 5+) and parks director 12 27 is marked other er traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman H. Willey Edith Brannock ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Charles Hachmeister Jr. husband 15 Merryweather Dr., Cambridge, MD permit. Pages 1 and:
Department of Health
Important; If item 27
any injury or other tr of Health 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/28/09 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Mem. Park 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 3 years Physician Pulmon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has al director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2,XNo Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 1/2001

M.D.

408

32. Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Mal

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra:Amend#19b, PerFHPGC7-29-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20:22 21, 2009 Jackson July Evon Α. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Min. Days Hours 1 □ M 2 🙀 F 8-11-1937 Washington, DC Director 71 579**-**46**-**6021 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Worlds Examinating in the molling and 1√Yes 2 No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 900 G Street N.E. 20002 United States Funeral Apt 820 death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: \$ 3 ☐ Widowed 4 ☑ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie Gregory Marable ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grayling Lane Rockville MD 20852 Earl Joyner/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 7-28-2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Licensee 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RESPIRATORY **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner TATUS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ARDIAC Due to (or as a consequence of): P.O. Box 68760, SPIRATI PNEUMONIA Physician/Medical 01 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Wes decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐Yes 2 ☐No 1 □Yes 2 ₩No Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 D Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Medical State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chandra Korapati,MD. 7600 Carroll Ave Takoma Park, MD 20912

deseller

31. Date filed (Month, Day, Year) JUL 2 8 2009

29b. Signature and title of certifier

32. Registrar's Signature

asypat. MD MD52855

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05683 State of Maryland / Department of Health and Mental Hygiene t ena Johnson 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death Physician/ Decedent's Name (First, Middle,Last) Month Day July 20, 2009 1236 hrs OHNSON Medical Examiner ENA ElizAbElh 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico Peninsula Regional Medical Center Salisbury Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Min Director - 4-1945 2×F M Yrs -44 - 7945 Usual Residence of Decedent 10d. Inside City Limits I0c. City, Town or Location M 10b. County 1 XYes 2 No 23a or 28a-f show Alis buen Wicom: Co event, the Medical Examiner must be notified at once. ARVIAND within 72 hours after death with the Maryland Director 10g. Citizen of What Country 10f. Zir Code 10e. Street and Number 21804 203 AP USA INTER DURN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status "natural", or items Armed Forces? 1 Never Married 2 Married Yes Specify: BIACK If Yes. Give Year 2 No specify: Divorced Widowed 4 à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) item 27 is marked other than r traumatic event, the Medical MD 21215-0036 NONE omeslic OS Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) TARKER William Be ElizAbeth ONNSON (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Md 2185 1- : 5 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Ξ 1 X Burial 2 Cremation 3 Removal from State CEM ma HCRES mportant: REEN Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home me NERAI Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each fine /Medical Death a Intracerebral Hemorrhage Immediate Cause (Final disease taminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Vear 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Yes 2 ✔ No 9 Unknown detached for Unknown cate has been signed by the page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. þ No 3 ✔ Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? Yes 2 1 V Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: director, Be Other<sub>4</sub> examiner? Hospital: Nursing Home 5 Residence 6 2 V ER/Outpatient this Inpatient ဥ 1 ✔ Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury Certification: 1 V Natural Yes 2 Pending in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc within 24 hours after To the Funeral Direc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified July 21, 2009 O.C.M.E. leted cause of death (Item 23a) 30. Name and address of person 111 Penn Street, Baltimore, MD 21201 Pamela E. Southall, MD Assistant Medical Examiner 31. Date filed (Month, Day, Yor)4 Registra

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 5:05 A M 27 2009 Roland Kennedy July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester General Hospital Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** 1 X M 2 □ F 81 Director 215-26-2620 May 18,1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 USA 6678 Palmers Mill Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumation. Black, White, etc 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Food Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Thomas Kennedy Eva Viola Christopher ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin McAllen-Davis/Daughter P. O. Box 164, East New Market, Maryland 21631 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

21. Sign turn of P ineral Service Lights Bloomery Cemetery 7/30/2009 Smithville, Maryland 22 Name and Address of Facility Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 28a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cute Tena week /Medical Due to (or as a consequence of) Examiner Cardiorena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cas Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 [2]Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 2 ER/Outpatient 3 DOA After this Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident i Director; filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 50804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 408 M.D. Street 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 Kremer Betty /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** OSPIC omic 1.0 9. Birthplace (State or Foreign Country) West Virginia 8. Date of Birth (Month, Day, Y If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Year) 1 □ M 2 🛛 F Months 236-34-3590 Director 83 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exp. after must be notified at 1X Yes 2 □ No Director Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 687 North Park Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married Specify: White 1 ☐Yes 2X No Specify þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Be Adkins Alice ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 687 N. Park Drive, Salisbury, Maryland 21804 Edward J. Kremer - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-24-2009 Delmar, Delaware 4 □ Donation 5 □ Other (Specify) Crematory of Delmarva: 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensée 705 E. Main Street, Salisbury, Maryland 21804 23a. Part Enter the disease, or compile sor's that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MRTASTATIC CARCINOID **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Year Month 4 🔲 Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 27 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes & Mo funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) HOSPICE Ø □ No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of confif D0058410

DHMH 17 Rev 1/2001

Registrar

G HWWW

31. Date filed (Month, Day,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8.0

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_ State	ate of Maryland /		rtment of H ificate of D				94 94 PA	0.71.0.7	
	_	Registrar  1. Decedent's Name (First, Middle, Last)		Cert		realli	2. Date of Dea	leg. No.	UU 9	3. Time of Death	
Physicia	ın	Anna Ruth Kirkland					Month 07	Day 18	Year 2009	11/3 A M	
/Medic Examin		4a. Facility Name (If not institution, give stree	and number)		4b. City, Town, or	Location of De		10	nty of Death	111271	
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Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	birthday)	If Under 1 Year   Months Days	If Under 24 H		1		lace (State or Foreign	
Director		217-44-0896 1 <sup>1</sup>	<sup>21</sup> XF 80	Yrs.	IVIOTILITS Days	Tiodis IVII	Aug 30			Known	
and w		Usual Residence of Decedent  10a, State 10b, County	10c. City, To	wn or Loca	ation				11	0d. Inside City Limits	
/laryli	o	MD Wicomico		sbury						1 √Yes 2 No	
the l	rec	10e. Street and Number	Sali	Sour	10f. Zip Code			10g. Citizen o	of What Coun	itry?	
be filed within 72 hours after death with the Maryland tall Hygiene. And the then "natural", or items 23a or 28a-f show event, it as fundical Evariation must be multipled at	Funeral Director	411 N. Poplar Hill A	venue		21801			USZ	A		
deatl	ner	11. Marital Status 12. W	as Decedent Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar	spanic Origin?	(Specify Yes or No-	14. F	Race - Americ		
or ite		1 ☐ Never Married 2 ☐ Married 1	∐Yes 2⊠No Yes, Give		Tes, specify Cubai ⊒Yes 2√g No	Specify:	ento moan, etc.)		llack, White, e		
ural",	d by	3 ⊠ Widowed 4 ∐ Divorced Y	ear or Dates:								
"nat	Completed	15. Decedent's Education (Specify only highest grade con	ppleted)	(Give k	nt's Usual Occupa ind of work done d O NOT use retired	urina most of w	vorking	16b. Kind of	b. Kind of Business/Industry		
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offiled other ent,	0	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Surn	ame)		
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2 shoil and I is ma		19a. Informant's Name/Relationship (Type. P		_	•		Rural Route Numbe				
and and m 27		Constance Ladd/frien					venue, Sa				
ges 1 If of H If Ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remove			tion (Name of atory or other place	)	Date	20c. Locatio	n - City or To	wn, State	
t. Pa rtmer rtant;		4 Donation 5 Dother (Specify)	Gree	n Acr Moria	es 1 Park Name and Addres	7/2	27/2009	Salis	sbury,	MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Inpepartment of Health and Mental Hygiene. In a marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it will marked at once.		21. Signature of Fineral Service Licensee	1100	Le	wis N. W	atson F	uneral Ho	ome, PA	4		
		23a. Part 1. Enter the disease, or complication	as that caused the death. Du				Salisoury		801_	Approximate	
Dhusisian		shock, or heart failure. List only one callimmediate Cause (Final	use on each line.		_		160			Interval Between Onset and Death	
Physician / /Medical		disease or condition resulting in death)	Due to (or as a consequence		wel	003	truck	con		23 days	
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at the de by the	Phys	9 Unknown	Unknown								
5 5 5	by P	Part II. Other significant conditions contribu	ing to death but not resulting	in the und	erlying cause give	n in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?	
v require been si should b		Casenlial,	Hyperles	exe	3~		_ 1 DY	es 2 <b>2</b> No	3 Prob	pably 4 🗍 Unknown	
law r las be 2 sh	Completed	Diabeter	mell	ite	ردي		24a. Was autop	sv	b. Were auto	psy findings available mpletion of cause of	
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Phys this al dir	<u>은</u>	IL tes ZEINO	1   Inpatient 2   ER/C	Outpatient Time of		4 🗆 Nursing	Home 5 Resid		Other (Specif	y) Hespice	
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l or Attendi after death. Director: A d in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be 28	e. Place of Injury - At home,	farm, stree		63 2 1110	28f. Location (S	treet and Nu	mber or Rura	al Route Number,	
al or A safter I Direct	Certification:	4 Homicide	building, etc. (Specify)				City or Tow	n, State)			
'S 3 5 5			n: To the best of my knowled								
the Horin 24 the Fu	Medical	one)	On the basis of examination and manner stated.	ang/or inve	sugation, in my op	omion, death oc					
To t To t	Σ	29b. Signature and title of certifier	17 00		29c. License				ned (Month,		
h		Jugari M.	Dellas	Ð_	12	450	5	07-	18-	2009	
1501	4	30. Name and address of person who comple								. 5 . 4	
Stat	0	GREGORIO M. BELL 31. Date filed (Month, Day, Year)	32 Registrar's Signature	020	HINVBEI	rry di	R., SALIS	UKY,	MD 2	1801	
Registra		JUL 2 4 2009	Circus B.	do	Kar						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8-3-2009 1:52 A M Sharon Lee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Northampton Manor Care Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Min 1 □ M 2 🕱 F 037- 32-1843 Yrs 11-18-1946 Director 62 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County od other than "natural", or items 23a or 28a-f show event, it a Medical Examinat must be notified at 1 X Yes 2 □ No Director Frederick Frederick MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 **USA** 813 A Stratford Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ 3 Widowed 4 N Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Claims Adjuster Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 1s marked, any injury or other traumatic evonce. Doris Phillips Gene Dorman ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18803 Preston Road Hagerstown, MD 21742 Daughter <u>Jennifer Knight</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Smithsburg Crematory 8-4-2009 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford P.A. F.H. 21. Signature of Funeral Service Lice 106 East Church Street Frederick, MD 21701 M01176 23a, Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Seiss DAKS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): MONTHS Examiner Chronic healing wound Non Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 XNo 5 Other (specify) the signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🙀 No 3 Probably 4 Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2 ☐ No 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Lursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29d Date signed (Month, Day, Year) 29c. License number itle of certifie 29b. Sid 10062221

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

FREDERICK MD- 4702.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAYEEN BOLANUM TO 196 TO DUVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yea Month. **Physician** 0533A M LLIAN 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITAL DORCHESTER DORCHESTER GENERAL CAMBRIAGE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Yrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 □ M 2 🛂 F Days Director Marylano Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho 1 Ves 2 No by Funeral Director Westbury Nassau 10g. Citizen of What Country? 10e. Street and Number 115 U 5 A Magnolia death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐Yes 2 🗹 No 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hyglen Important: If item 27 is marked other the any injury or other traumatic event, In. 2000. Someone else's home Work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Algie Lankford ဂ္ဂ Arletta 19a. Informant ame/Relationship (Type. Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue, Westbury New York 11590

Date 20c. Location City or Town, State Jerry 41 Magnolia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery HUYlock, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address (Facility
HENRY FUNERAL HOM'S
10 Washington St 21. Signature of Funeral Service Licenses MD. 21613 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 ☑No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Itimore,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit

Certification: To

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abul Foyez Arifuddowla, MD 300 Byrn Street, Cambridge, Md 21613

State Registrar

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Onuk (qu)

28 2009

MD

30. Name and address of per

Adaku 31. Date filed (Month, Day, Year) 29c. License number D65953

1500 Forest Glen Rd. Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

7/25/09

and manner stated.

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ZUUU Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** P M RIQUELME ESTIBEN YAQUE LOPEZ July 2009 7:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral ₩** M 2 F Months Days Hours Min. Director 2009 Maryland 6 July 29, Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show The Medical Expedient must be notified at 10d Inside City Limits Director MD 1 XYes 2 No Frederick Frederick 10f. Zip Code 21703 10e. Street and Number 10g. Citizen of What Country? 1204 Aynsley Court, Apt. 1C United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Was Deceuc... \_ Armed Forces? 1 ∏Yes 2XINo 1 ☐ Yes 2 X If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married 1 XYes 2□No Specify:Salvadoran Baltimore, Maryland 21215-0036 \$ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H fitem 27 is marked oth r other traumatic even Ronaldo DeJesus Yaque Cervantes Ines Lopez 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ines Lopez/ mother 1204 Aynsley Ct, Atp. 1C, Frederick, MD 21703 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 ☐ Burial 2 T Cremation 3 ☐ Removal from State Smithsburg Crematory 8/4/2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen; 22. Name and Address of Facility Keeney & Basford Funeral Home MO1222 106 E. Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2le disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Dun to (or as a nonsequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death Day signed by the a 5 Other (specify) 9 ☐ Unk*n*own Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed 1 □Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 29925 FREDERICK MEMORIAL FREDERICK MO J 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

LEON420

31. Date filed (Month, Day, Year)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	,	Certifica	te of	Death		R	eg. No.	003 2343			
Physic	an/	Decedent's Name (First, Middle,L						2. Date of Dea Month	Day Year	3. Time of Death 2117 hrs			
Medical Exam	iner	JOSEPH MICH  4a. Facility Name (if not institution,		S	141	b. City, Town, or L	ocation of De	August 2,	4c. County of D				
		Shady Grove Hospital	give street and number)				Rockvi		Montgome				
Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last birth	day)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	rth (MM/DD/YYYY)	9. Birthplace (State or Foreign			
Director		218-04-2219 1	<b>X</b> M 2 F	30	Yrs.	Months Days	Hours	Min. April	1, 1979	Country) Maryland			
		Usual Residence of Decedent											
W SIL		10a. State 10b. County		0c. City, Town o						10d. Inside City Limits  1 X Yes 2 No			
yland yland t-f sho	tor	Md. Mont	gomery	Gai	ther	sburg 10f. Zip Code		T <sub>1</sub>	log, Citizen of What				
6 K ne Maryland or 28a-f show any fied at once.	Director	107 Tulip Drive		208	377		•	United States					
s 23a	ral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was			( Specify Yes or No		American Indian, Black,			
death ritem	Funeral	1 Never Married 2 Marri	Armed Forces?  1 Yes 2	€ No	If Ye	s, specify Cuban,	Mexican, Pu	erto Rican, etc.)	White, 6	white			
after	by F		ced If Yes, Give Year or Dates:			Yes 2 X No			Specify:				
hours natur Exam	ted t	15. Decedent's Education (Specify		d		s Usual Occupations of story			16b. Kind of Busir	ness/Industry			
36 hin 72 e. than '	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	,	Ins	taller			Air Con	ditioning			
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215 be file ntal H rked	Be (	Joseph Mathis					Roxi	e D. F	erguson				
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Hand and Mental Hygiene.  In: If item 27 is marked other than "natural", or items 23a or 28a-f sho mit. If item 27 is marked other than "natural", or items 23a or 28a-f sho not the traunnatic event, the Medical Examiner must be notified at once.	မ									State, Zip Code) 20877			
MD and 2 sho ealth and em 27 is raumati		20a. Method of Disposition				tion (Name of cer		Date		ity or Town, State			
Baltimore, M bermit. Pages I and 2 Oppartment of Health mportant: If item 2 njury or other traun		1 X Burial 2 Cremation	3 Removal from State	e cremato	ry or oth	erplace) rings Ce	·	8/7/09		Springs, Md.			
E 5 5 7 7		4 Donation 5 Other Spec 21. Signature of Funeral Se y ce Lic	cify:	TOPIG						Springs, ra.			
Balti permit. Departm Imports		Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 2088											
Physician		23a. Part I. Enter the disease, or co failure. List only one cause or		ne death. Do not	enter th	e mode of dying,	such as cardi	ac or respiratory an	rest, shock, or heart	Approximate Interval Between Onset and			
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cords, P.O. Box 68 law requires that the death certif has been signed by the attending 2 should be detached for use as	by Pł	Part II. Other significant condition	ns contributing to death	but not resulting	in the u	nderlying cause g	iven in Part I.			ute to the cause of death?			
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Division of Vital Records, P. Isto a Attending Physician: The law requires the state death. The Tal Director: After this certificate has been signed to by the funeral director, page 2 should be do	fical	2 Accident Investig 3 Suicide 6 X Could r	280 Place of Inju	ry - At home, fa	rm, stree		uilding, etc.	28f. Location	(Street and Number	or Rural Route Number, City			
Div pital o ours af filled i	Certification:	4 Homicide		resider	ice			Gaither	State) 107 Tu sburg, MI	) ) )			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		Tollow olly	sician: To the best of my										
28. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated.  29b. Signature and title of certifier 29c. License number 2													
	2	29b. Signature and title of certifier		1	1	29c. License O.C.N			August 3, 20	(Month, Day, Year)			
		20 Namo and address of		ath (Hom 22=)		<i>-</i> 0.0.1	***		7.109001.0, 20				
_		30. Name and address of person was Zabiullah Ali, M.D. As	no completed cause of de ssistant Medical Exa		1 Peni	n Street, Balti	more, MD	21201					
S	tate	31. Date filed (Month, Day, Year)	2000 32. Registrar's		1								
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			For State Registrar		State of	Marylan		rtmen <i>tificati</i>			ind Me		giene Reg. No.	200	9 23	5431	
	6		Decedent's Name (F	irst, Middle, Las								Day	3. Time				
	Physicia /Medic		Mary	Е.	McCormi							July		35 P <sup>M</sup>			
Cont.	Examin	er	4a. Facility Name (If no Brightwo			ber)	i de la companya de l			Location o				County of Dea Baltimo:			
	Funeral	其	5. Social Security Num			. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birtl (Month, Day	1	9. Bir	thplace (State	or Foreign	
	Director		190-38-67	66 1	□M 2 <b>½</b> F	61	Yrs.	Months	Days	Hours	Min.	10/02	/194		nsylvar	nia	
	pun		Usual Residence of De	cedent b. County		10c. Cit	y, Town or Lo	cation							10d. Inside	City Limits	
	Maryla f sho	lor		Anne Arı	ındel				Crof	ton					1 □ Ye	s 2 XNo	
	r 28a-	Director	10e. Street and Number					10f. Zip	Code				10g. Citiz	zen of What C	ountry?		
	th with unit 23a oust be		1731 Dana	Street					211					USA			
	er dea Items ner mi	Funeral	11. Marital Status	O Marriad	12. Was Deced	ces?	.S. 13.	Was Deced If Yes, spe	dent of Hi cify Cuba	spanic Ori n, Mexicar	gin? (Spec 1, Puerto F	city Yes or No- Rican, etc.)		14. Race - Am Black, Whi			
36	irs aft	by F	1 ☐ Never Married 3 ☐ Widowed 4 [		1 ☐ Yes If Yes, Give Year or Da	tes:		1 🗆 Yes	2XNo	Specify:			:	Specify:	White	9	
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≥	and 2 ealth m 27 i		Melissa Mc		/Daughte		107 Place of Dispo			ings		Owings		Lls, MD			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispos 1 ☐ Burial 2 ☐	Premation 3 □		state (	cemetery, crei	matory or o	other plac	i				cimore,		- Para	
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Ba	permir Depar Impor any ir once,		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715														
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/×	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit	Physician/Medical	IF FEMALE: 23b. Was decedent p	roonant	23c. If yes, outo	come pf pregn	ancy							23d. Date of d	elivery		
% % %	death e atter	icial	in the past 12 m 1 Yes 2	onths?		rth 2 ☐ Feta ant at time of		⊒Ectopic p ⊒ Other <i>(s</i>		/				Month	Day	Year	
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Ym/	i <b>lcian:</b> The lav certificate has ector, page 2	Be Co	25. Was case referre	d to medical						26. Plac	e of Death	(Check only		, , , , , , , , , , , , , , , , , , , ,	25,140		
or Vital	Physician: r this certificaral director, i	To E	examiner? 1 ☐ Yes 2 ☐ N			npatient 2				4 E N				6 □Other (Sp	pecify)		
	ing P After t unera	on:	27. Manuer of Death 1 Natural	5 Pending		of Injury h, Day Year)	28b. Time of Injury	of M	28c. Injur Wor	yat k? Yes 2.⊡		28d. Describe	ribe how injury occurred				
Division	Attending r death.  sctor: After y the funer	Certification:	2 ☐ Accident 3 ☐ Suicide	investigation  6 Could not be determined		of injury - At h	 iome, farm, st			103 2		28f. Location (	Street ar	nd Number or	Rural Route N	lumber,	
O V	al or A s after Il Dire	erti	4 Homicide	determined	buildir	ng, etc. ( <i>Spe</i> c	ify)					City or To	wn, State	Đ <i>)</i>			
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	cal	29a. Certifier 1 (Check only 2	Certifying PI	nysiclan: To the	best of my kn	owledge, dea	th occurred	d at the ti	me, date a opinion, de	nd place, ath occur	and due to the red at the time	cause(s , date an	and manner d place, and d	as stated. ue to the caus	se(s)	
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	/		30. Name and address	s of person who	completed_caus	e of death (Ite	m 23a) (Type,	Print)	5	BAY	TWF	HIR	AT.	rea )	m		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MUNGUI RONDR 200 HI /Medical Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner Itwapelis Under 1 Year If Under 24 Hrs. ove 8. Date of Birth (Month, Day, Ye Nov. 28, 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> 1928 80 1 M 2 X F 556-62-0750 Director Mexico Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show 1 □Yes 2 🗓 No Director Maryland Anne Arundel **Annapolis** the ! 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2594 Twin Landing Cove U.S.A. 21401 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 鳌西 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status XX Never Married 2 Married Baltimore, Maryland 21215-0036 1XXves 2 □ No Specify: Mexican White Specify: 3 Widowed 4 Divorced er than "natura", the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Textiles | 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If item 27 is marked ot any injury or other traumatic even once. unknown Lucia Larios de Munguia ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2594 Twin Landing Cove Annapolis, Maryland 21401 Gary Bahena/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Baltimore Crematory : 7/18/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 0 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e cause Immediate Cause (Final **Physician** tile to (or a val consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the chiral Cause (Disease or injury that initiated events resulting in death) Last (or as a cons \* uence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 5 ☐ Other (specify) signed by the a d be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 (2 No 3 Probably 4 Unknown cate has been a 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐ Yes 2 ZAN 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 7/16/09 UNK M 1E 28e. Place of Injury At home, farm, street, factory, office building, stc. (Specify) Jub 2 🔀 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 4 ☐ Homicide 29a. Certifier Medical and manner stated eputy 29d. Date signed (Month, Day, Year)

State Registrar m

Name and address of person who completed cause of death (Item 23a) (Type, Print) o'nes

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 7/15/2009 **Physician** M William F. Moore, Jr. 1406 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6/24/1926 Birthplace (State or Foreign Country) **Funeral 1**√2 M 2 □ F 579-30-5849 83 DC Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprinter must be notified at any injury or other traumatic event, the Medical Exprinter must be notified at any injury or other traumatic event, the Medical Exprinter must be notified at any injury or other traumatic event, the Medical Exprinter must be notified at any injury or other traumatic event, the Medical Exprinter in the notified at any injury or other traumatic events. Director 1 ☐ Yes → No MD Anne Arundel Churchton 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 5613 Carroll St. 20733 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1X2X es 2 □ No Black, White, etc. 12 Dayes 2 ☐ If Yes, Give Year or Dates: WWII 1 ☐ Never Married 3 ☐ Married 1 ☐ Yes 2x No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William F. Moore, Sr. Thelma Holstein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Sanders Moore Wife 5613 Carroll St. Churchton, MD 20733 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Our Lady of Sorrows 7/20/2009 West River, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Jaki Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 50 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner P5.5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗹 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 40 1 ☐ Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \'(Specify) \) 2 4 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation after death.

I Director: Aff 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P000<829 ll 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNG 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Street a/bo+ =aston If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 ☐ M 2 🗹 F 217-28-556 Usual Residence of Decedent 336 Director Oct. 10 Maryland death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Experiment must be neithed at 1 Ves 2 No ИD Director albot 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 21601 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Seçondary (0-12) College (1-4or 5+) HOSP: ta Service / O ronmental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be har les Addison ၉ BSON Beulah Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street Easton v. Mary land 2/60/20c. Location - City or Town, State Wanda August 20a. Method of Disposition 20b. Place of Disposition Wame of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State terans Cemetery 7/31/09 4 Donation 5 Dother (Specify) Hurlock, Maryland 22. Name and Address Facility 21. Signature of Funeral Service Licensee Home, P.A. HENRY FUNERAL washington stic 23a. Parti / Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Breast (group Yr. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) the detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No · has 24a. Was an Q autopsy bage, this certificate 2 No 1 □Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Pars Local Control Hospital: 1 ☐ Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 □ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Box 68760 P.0. of Vital Records, Division

> State Registrar

Medical

30. Name and address of person who completed cause of death (Item 200) (Type, Print)

29b. Signature and title of certifier

Date filed (Month, Day,

verson

29d. Date signed (Month, Day, Year)

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		Registrar  1. Decedent's Name (First, Middle, La	ist)	061		Dealli	2. Date of Dea		3. Time of Death
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s 1 an of Hea item 2		20a. Method of Disposition				<sup>ce)</sup> July 28		20c. Location - City	·
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State Registrar

DHMH 17 Rev 1/2001

30 thang and eddress of person who composed as a second se

09-06056 James Mitchell

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ıme	s Mitchei	1	1	For State	or Maryland / De	Certificate		a Montai 11	Reg.	No. 20	109 2543
	Physic	iar		egistrar . Decedent's Name (First, Middle,La					2 Date of Death		3. Time of Death
ledi	ical Exan			James Robert	Mitchell, J	ír.			Month D August 3, 20	09	1607 hrs
			4	a. Facility Name (if not institution, g	ive street and number)		,	Location of Death		4c. County of Dea	th
			Н	7140 Sharpsburg Pike			Hagerstowr			Washington	Sittle of the Color of
	Funera	al		5. Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Day			MM/DD/YYYY) 9. E Fore	eign
	Directo	r	-	214-42-2890	X M 2 F	65	Yrs.	is Hours Will.	Feb. 18,	1944 Was	himoton, D.C.
		1	Ŀ	Jsual Residence of Decedent							10d. Inside City Limits
	y any			10a. State 10b. County	10c.	City, Town or Lo					1 Yes 2 X No
^	and show	ng.	5	4	ington	B	oonsboro		140-	. Citizen of What Co	
0	Maryl		Director	10e. Street and Number			10f. Zip Code	01.01.0	109		
1	the 3a or			7140 Sharpsburg				21713		US.	erican Indian, Black,
1	ath with the Maryland items 23a or 28a-f show	e u		11. Marital Status  1 Never Married 2 X Marri	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? ( Sp in, Mexican, Puerto	Rican, etc.)	White, etc.	
	deat	must	뒤		1 Yes 2AA	No I	Yes 2 X No	a specific		Specify:	White
	s after	١٩	ᅪ	3 Widowed 4 Divorce 15. Decedent's Education (Specify	ed If Yes, Give Year or Dates:		dent's Usual Occupa	_	work done 1	6b. Kind of Busines	ss/Industry
	hour	Exa	된	Elementary/Secondary (0-12)	College (1-4 or 5+)	durin	g most of working life	e. DO NOT use reti	red)		
	within 72 yiene.	g .	읪	11	JS.1030 (1 1 51 2 )		Printe	er		Printing	Company
	5-00 iled with Hygiene	the Medical Exami	Completed	17. Father's Name (First, Middle, La	st)			18.Mother's Name	e (First, Middle, Ma	iden Surname)	
	21215-0036  uid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho	# #	e l	James Robert	Mitchell, S	r.		Doroth	4	nayer	
		5	0	19a. Informant's Name/Relationship		19b. Ma	iling Address (Stre	eet and Number or	Rural Route Numb	er, City or Town, St	ate, Zip Code)
	MD 12 sho th and	nmat		Regina K. Mitch	ell - Wife				Boonsbo	20c. Location - City	and 21713
	ore, MD 2 ss 1 and 2 should by Health and M If item 27 is m	r tra		20a. Method of Disposition  1 Burial 2 XXCremation			position (Name of cor r other place)	emetery,	Date	20c. Location - City	Or Town, State
	S 40 =	a 1		4 Donation 5 Other Spec		Smithsbu	urg Cremat	ory Aug	.5, 2009	Smithsbu	rg, Maryland
	Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is	ury o	t	21. Signature of une Service Lie	ensee	Ĉ	SHOTTE	inéfall Ho	me, P.A.		
	<b>m a</b> a a .	:E	(	B1117 ()	su		125 S. Cor	nococheag	ue St. W	illiamspo	ort, MD 21795
7	Physicia			23a. Pan 1. Enter the disease, or co failure. List only one cause or	each line.					st, SHOCK, OF HEAR	Between Onset and Death
7	/Medic	-	1	Immediate Cause (Final disease	Atheroscler		diovascu]	lar disea	se		Death
				or condition resulting in death)	Due to (or as a conseque	ence of):					
		ı	卢	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):					
			ij	cause. Enter Underlying Cause (Disease or injury that initiated	c						
	-pa	ısıt	Examiner	events resulting in death) Last	Due to (or as a conseque	ence of):					
	Division of Vital Records, P.O. Box 68760, fo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and			XUNPENDED	d. AMENDED 23a,	27,perMI	, g895 9/	25/09 TT			
	60, ate be e	burial	Medical		23c. If yes, outcome of					23d. Date of deli	ivery
	876 iffcat ng phy	is the		IF FEMALE: 23b. Was decedent pregnant in the	1 Live birth	2	Fetal death 3	Ectopic pregr	nancy	Month	Day Year
	Box 687 death certificathe attending p	r use	icia	past 12 months?	4 Pregnant at time	e of death 5	Other (Specify)				
	Bo e deat the at	ed for	Physician/	1 Yes 2 No 9 Unkn	9 OHKHOWH		ul	a sives in Bort I	23e Did to	pacco use contribut	e to the cause of death?
	hat th	be detached	by P	Part II. Other significant condition	ns contributing to death bu	it not resulting in	the underlying cause	e given in Fait i.			Probably 4 V Unknown
	S, P.C nires that n signed								. 24a. Was a		re autopsy findings available
	cords law requi	2 should	Completed						autops	sy prior	r to completion of cause of
	The lar	age 2	ШО						1 ✓ Yes 2		Yes 2 No
	tal Recian: The certificate	tor, p	Be C	25. Was case referred to medical			26.Pla	ace of Death (Chec			
	Vits hysicia this co	direc	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	-				Residence 6 🗸 0	Other: Scene
	of ing Pt After	unera	n: T	27. Manner of Death  X Natural 5 Deading	28a. Date of Injury (Month, Day, Year)	28b. Tim		njury at Work?	28d. Describe r	ow injury occurred	
	ion tendi	the f	atio	Natural 5 Pendir 2 Accident Investi	nation			Yes 2 No	1001		or Rural Route Number, City
	Division of Vital Records, P.O. tal or stending Physician: The law requires that the realth death.	lin by	tific	3 Suicide 6 Could	not be	/ - At home, farm,	street, factory, offic	e building, etc.	or Town, S		or Rural Route Number, Only
	spital ours	filled	Certification:	4 Homicide determ	( - F 2)					A 5	atatod
	Division  Fo the Hospital or Attend within 24 hours after death To the Funeral Director:	letely		(	sician: To the best of my ki	nowledge, death	occurred at the time, stigation, in my opin	, date and place, ar ion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	to the cause(s)
	Divis To the Hospital or A within 24 hours after To the Funeral Dire	completely filled in by the funeral director, page	Medical	2	and manner stated.	and and of mive		ense number			(Month, Day, Year)
			Σ	29b. Signature and title of certifier				C.M.E.		August 4, 20	
		-		2-	) m						
4				30. Name and address of person v			111 Penn Stre	et. Baltimore	MD 21201		
91	4-6		-	Donna M. Vincenti, MD		Cignoture					
		St	ate	SI. Date filed (Month Ut. Yell)	2009 32. Registrar's	J.g.id.tile	parke				

DHMH 17 Rev 1/2001 OCME 2006

OCME

29 2009 723 **Physician** Elmer Stanley Moats /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Williamsport Washington 17114 Lombard Street If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Nov. 24, 1919 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs, last birthday) Months Days Hours 1**X** M 2 □ F Director 89 Maryland 212-14-6862 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show The marked other than "natural", or items 23a or 28a-f show traumatic event, the Mariest Examiner must be reallised at 1 ☐ Yes 2 No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21795 17114 Lombard Street USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify Specify: White WWII 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any hijury or other traumatic event, Ite Madia once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Mechanical Engineer Railroad Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luther James Moats Sr. Anna May Cline ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William McBratney (Nephew) 3326 Chippendale Ave. Philidelphia, PA 19136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Manor Cemetery July 31, 2009 | Boonsboro, Maryland 21. Signature of Funeral Service Lice Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, Maryland 21795 23a. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jue to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hriknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □Yes 2 🖼 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury
(Month, Day, Year)

July 28, 1009 1635 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation winn I hot 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☑ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28e. Pl. ce of Injury - At home, farm, street, factory, office building, etg. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide The Leading To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and fitle of certifier 29c. License number 29d. Date signed (Month, Day, Year) W& to III M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1901/ oxland tenace Back. WH 441 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last)

Reg. No. 🛴

2 Date of Death

3. Time of Death

Physician
/Medical
Examiner

I. Decedent's Name (First, Middle, Last) Edward Gabriel Misey 2. Date of Death

July 22,

3. Time of Death 6:10 a M

a. Facility Name (If not institution, give street and number) Renaissance Gardens at Riderwood Village 4b. City. Town, or Location of Death Silver Spring

4c. County of Death Prince George's

2009

**Funeral** Director

ns 23a or 28a-f show must be notified at

"natural", or items

it of Health and Mental Hygie If Item 27 Is marked other I or other traumatic event, In

Department of Important: If It any Injury or o

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Director Funeral <u>م</u>

7. Age (In yrs. last birthday) 1 M 2 □ F 90

If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

8. Date of Birth (Month, Day, Oct. 1, 1918

9. Birthplace (State or Foreign Wisconsin

387-07-7187 Usual Residence of Decedent 10a, State 10b. County

5. Social Security Number

Maryland Montgomery Silver Spring

10c. City, Town or Location

10d Inside City Limits 1 ☐Yes 2 No

10e. Street and Number

3112 Gracefield Rd., PV-511

20904

10f. Zip Code

10g. Citizen of What Country? USA

11. Marital Status

12. Was Decedent Ever in U.S. 1 Never Married 2 Married 3 XWidowed 4 □ Divorced

Was Deces? Armed Forces? ▼Ves 2 □ No If Yes, Give Year or Dates: 1942-43  Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify White

15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Completed Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last)

Lawyer

US Dept. of State

John J. Miscy

19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Pauline Catherine Fojut

18. Mother's Name (First, Middle, Maiden Surname)

Johanna Misey Boyer/Daughter

702 Twin Holly 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lane, Silver Spring, MD 20910 Date 20c. Location - City or Town, State

20a. Method of Disposition

Immediate Cause (Final

disease or condition resulting in death)

1 Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Holy Cross Cemetery

Milwaukee, Wisconsin

21. Signaturg of Funeral Service Licenses revalo

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

<sup>2</sup> Phane Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death

**Physician** /Medical Examiner

law requires that the death certificate be execute

page 2 should be detached

certificate I

this

After 1

ne Hospital or Attending Po n 24 hours after death. ne Funeral Director: After t

To the Hosp within 24 hor To the Fune completely fi

funeral director,

filled in by the

Box 68760,

Division of Vital Records, P.O.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-tran

congestive Due to (or as a consequence of): ancmia Due to (or as a consequence of)

gastrointestinal Due to (or as a consequence of)

Physician/Medical

à

Completed

Be

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

1 □Yes 2 □No 9 Unknown

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy nerforme 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

Year

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death 5 Pending investigation

6 Could not be

determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

3110

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29a. Certifier (Check only

1 Natural

2 Accident

3 Suicide

4 Homicide

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

ion Mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rachelle Alexian 31. Date filed (Month, Day, Year)

27

Gracefield Rd 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

2 No 1 ☐ Yes

26. Place of Death (Check only one) skilled hursing tacili Other: 4 \subseteq Nursing Home 5 \subseteq Residence

6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D44156

Silver Spring, MD 20964

2009

	1	For State Registrar	State of Marylan		tificate			nontar .	Reg. N	6000	2543
		1. Decedent's Name (First, Middle, Las	st)					2. Date o		ay Year	3. Time of Death
Physicia		Leonard	Arnell Moore					July		2009	4:50p
/Medic		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death						c. County of Deat	
LAdmin	21 21	Villa Rosa Nursi			Bowie					Prince G	eorge's
Funeral		5. Social Security Number 6. S	ex 7. Age (In vrs.	last birthday)	If Under 1		nder 24 Hrs.	8. Date o			hplace (State or Fore
Director	-	579-64-4038  Usual Residence of Decedent	M 2□F 60	Yrs.	Months C	Days Ho	urs Min.	07-11	Birth , <i>Day</i> , Yea -1949	Wash	ington, Do
f Health and Mental Hygiene. Item 27 ie marked other than "natural", or Items 23a or 28e-f ehow other traumatic event, the Medical Examiner must be notified at	2	10a. State 10b. County		y, Town or Lo							10d. Inside City Lim 11 Yes 2 ☐ I
- 88	Funeral Director	MD Prince G	eorge s	Suitla	10f. Zip C	a da			100.0	itizen of What Co	untry?
20.0	2	10e. Street and Number			207				U.S		one y
s 23	ra	2307 Whitehall St	12. Was Decedent Ever in U	C 12 1			o Origin? (Sr	acriv Vac		14. Race - Ame	rican Indian
Fe a	nu	11. Marital Status	Armed Forces?	.5.	Was Deceder f Yes, specify	Cuban, Me	xican, Puerto	Rican, etc	)	Black, Whit	
tural', or ite	by F	1   Never Married 2 Married  3   Widowed 4   Divorced	1 ☐ Yes 2 M No If Yes, Give Year or Dates:		1 ☐ Yes 2∑	No Spe	ecify:			Specify: B1a	ick
E E	pe	15. Decedent's Ed		16a Decec	dent's Usual (	Occupation			16b.	Kind of Business	
a S	Completed	(Specify only highest gra	de completed)	(Give	kind of work	done during	most of worl	king			,
than	m C	Elementary/Secondary (0-12)	College (1-4or 5+)		EOC	,			GO	vernment	
al Hygiene. I other than " vent, Ite M	ပိ	17. Father's Name (First, Middle, Last)	<u>Z</u>			18. N	Aother's Nam	e (First, Mi	ddle, Maide	n Sumame)	
d ol	Be					Mary Marable					
and Mental le marked sumatic ev	ဥ	Otis Moore Mary Marable  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State)									Zin Code)
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Health				Place of Dispo			e Dr.	Date		ngton, N Location - City or	
if of h		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □		cemetery, cren	natory or othe	er place)	I	5415			
ant:		* 4 □ Donation S □ Other (Span)	y) Ha	rmony				1-09		dover, M	
Department of Health Important: If tem 27 any injury or other tr once.	21. Signature of Funeral Service Licensee 22. Name and Address of Facility. H. Bacon Funerla I										ne, Inc.
.05 = 8		MARIA BAR	164 CCO 25							DC 200	
3		23a. Part . Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	th. Do not ente	er the mode	of dying, suc	ch as cardiac	or respirate	ry arrest,		Approximate Interval Between
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sician and burial-transit	al Examiner	that initiated events	c								
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ysicie ie bur	cal	resulting in death) Last	c	quence of):						23d. Date of de	livery
anding physicie use as the bur	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	ancy	Ectopic preg					23d. Date of de Month	livery Day Year
anding physicie use as the bur	cal	IF FEMALE: 23b. Was decedent pregnant	c	ancy	Ectopic preg						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🏻 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month **Physician** Donald

4a. Facility Name (If not institution, give street and number) 20 2009 /Medical 4c. County of Death 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 10/11/1938 5. Social Security Number . Age (In yrs. last birthday, **Funeral** 202-28-9434 1 X M 70 Maryland **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ¥ Yes 2 ☐ No Maryland Worcester Snow Hill Examiner must be notified Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 208 W. Martin St. 21863 USA Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1.1 Marital Status Black White etc. 1 
 Yes 2 No
If Yes, Give Navy
Year or Dates: Navy 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify ģ Specify: 3 Widowed 4 Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Field Representative architecture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard H. Mahler Frances Souders ပ 19a. Informant's Name/Relationship (Type. Print)
Donna Mahler/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 W. Martin St., Snow Hill, MD 21863 Department of Health a Important: If item 27 is any injury or other trauonce. 20a Method of Disposition 20b Place of Disposition (Name of Date 20c Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Bates Memor 1 at place) 4 ☐ Donation 5 ☐ Other (Specify) Methodist Cemetery 7/27/09 Snow Hill, MD Thoricway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Lice Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician are for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Tectopic pregnancy Year Month Dav Pregnant at time of death 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \sum Nursing Home 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Certification: To eral Director: After this filled in by the funeral d 28b. Time of 28c. Injury at Work? 27. Manner of Death Date of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury 2 No 1 Tyes 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 24 hours 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I the 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

GABRIEL

31. Date filed (Month, Day, Year)

BRATI

32. Registrar's Signature

RES.

600 North Wolfe St, Baltimore, MD, 21287

-	For State Registrar		State of Maryland / Department of Health  Certificate of Dear					
. [	ecedent's Name (First,	Middle, Last)						
	Thomas	R.	Marine					

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	1 - State Registrar Certificate of Death							F	Reg. No.	100	C J 19 19 1	
	1. Decedent's Name (First, Middle, Last)							2	2. Date of Dea Month	ith Day	Year	3. Time of Death
Physici /Medic		Thomas R.	Mari	ine					July	21 2	2009	1:15AM
Examin		4a. Facility Name (If not institution, g BERLIN NURSING 8				4b. City, Town, or BERL		of Death	-		nty of Death	}
Funeral Director		214-28-8135	.Sex 1 <b>⊠</b> M 2∐F	7. Age (In yrs. <b>77</b>	last birthday) Yrs.	If Under 1 Year Months Days	Min. O	932	9. Birthp Coun Mar	place (State or Foreign htry) yland		
pur *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					1	0d. Inside City Limits
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the N 28a-	9 88 0 1 10e. Street and Number 10f. Zip Code											ntrv?
with 3a or it be									USA			
ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H		gin? (Speci	fy Yes or No-		ace - Americ	
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iral";	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates: Army	7	10 163 25110	opecity.			Spe	whi	te
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t. Pa rtmen rtant: njury		4 Donation 5 Other (Spe		Ch.	urch C	emetery Name and Addre	i	7/24/	09	Eldor	ado,	MD
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		21. Signature of Funeral Service Lic	Blan	ul		Holloway 501 Snow	Funer	cal Ho	me Pro Salisb	ofessio	onal As 1D 2180	ssociation 04
		23a. Fart1. Enter the disease, or co shock, or heart failure. List or	omplications that only one cause on e	caused the deat each line.	h. Do not en	er the mode of dyin	ng, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	_a. ASc	VD								Onset and Death
/Medical Examiner		resulting in death)	Due to	(or as a conseq	juence of):							
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uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or liqui) that initiated events		`	,						1	
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		23b. Was decedent pregnant in the past 12 months?	1 ☐ Live t	tcome pf pregna pirth 2  Feta	al death 3	Ectopic pregnancy	/				Date of delive Month	ery Day Year
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that the the detac		Part II. Other significant conditions	s contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I		23e. Did to	bacco use c	ontribute to th	he cause of death?
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aw require	Completed								24a. Was a		b. Were auto	psy findings available
The lavate has	lmo								autop perfor 1□ Yes	med? 2 No	death?	mpletion of cause of
sician: The certificate l rector, page	Be C	25. Was case referred to medical examiner?					26. Place	e of Death (	Check only or			
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ding Physician: The n. After this certificate he funeral director, page		27. Manner of Death  Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time o Injury	Wor			d. Describe h	ow injury occ	curred	
ttend death stor: /	icati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	be 290 Bloos	of injune. At he	ome farm et	M 1 ☐ eet, factory, office	Yes 2□		f Location (C	Stroot and Nu	mbor or Dura	al Route Number,
after Direction by	Certification:	4 ☐ Homicide determine	build	ing, etc. (Specif	fy)	eet, lactory, office		20	City or Tow		inber of Hura	i noute Number,
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death and the death to the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Medical C	29a. Certifier Check only one) Certifying 2 Medical Ex	aminer: On the b	e best of my kno easis of examina ner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	me, date ar opinion, dea	nd place, ar ath occurred	nd due to the o	cause(s) and date and plac	manner as s ce, and due to	tated.
o the vithin i	Mec	29b. Signature and title of certifier	and man	or stated.		29c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)
- > - 0		> Merly	_			0 63	3199			071	21/09	
10		30. Name and address of person wh	no completed caus	se of death (Item	n 23a) (Type,	Print)	, (	ALICA	25	14 7	GO I:	
Duc		YOGE SH VOHR		EASTE Registrar's Signa		Print) 1-1002E DR	ر , کا	1017R	01-1	10, 21	20.6	
Sta Registr		31. Date filed (Month, Day, Year)	nne /	egisirar s Signa	d be	exced						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Richard Month Francis Mayo Sr. 2009 20 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WICOMIC <u>Peninsula</u> Regional Malical Cente . Social Security Number 026–22–0814 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠**M 2□ F 79 Director 08/02/1929 Massachusetts Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits show ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho Injury or other traumatic event, the "Medical Examiner must be muffled at Director 1 X Yes 2 □ No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Schumaker Dr. 21804 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 The 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Mes 2 No Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 TNo þ Specify. Specify: 3 Widowed 4 Divorced Year or Dates: Army white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) t of Health and Mental Hygiene. detective private investigation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Walter Mayo Marguarite Shay ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erin Gray/daughter 709 W. Main St., Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eastern Shore of MD 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 ☐ Other (Specify) 7/27/09 Hurlock, MD Veterans Cemetery f Funeral Service Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that used the shock, or heart failure. List only one cause of each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mediate Cause (Final Physician /Medical Due t (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been si page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed certificate 2 No 2 No 1 □ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

gistrar's Signatu

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminal must be notified at once. Baltimore, Maryland 21215-0036

Physici /Medic Examir

**Funeral** Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	State of Maryland	•	artment of Health Artificate of Deatl			0	nno	251.1.1			
-	Registrar  1. Decedent's Name (First, Middle, Last)		inoute or beat		2. Date of Dea	Reg. No.	UU.	3. Time of Death			
an	Charlotte Gurley Matt	ern			Month Aug.	Dav	009 009	0200 A M			
al er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location	n of Death		4c. Count	y of Death				
-1	Casey House Hospice		Derwood			Mont	gomer	y			
	5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year   If Under	er 24 Hrs.	8. Date of Birtl (Month, Day	h	9 Birth	place (State or Foreign			
	577-40-2970 1□M 2\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Yrs.	Months Days Hours		Sept. 2	1930	of C	ntry)District			
	Usual Residence of Decedent										
_	10a. State 10b. County 10c. City,	Town or Loc	cation					10d. Inside City Limits 1   Yes 2   No			
cto	MD Montgomery Che	vy Cha									
	10e. Street and Number		10f. Zip Code			10g. Citizen of		ntry?			
<u>a</u>	4615 North Park Ave.		20815				S.A.				
nue	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of Hispanic ( f Yes, specify Cuban, Mexic	Origin? (Spe can, Puerto F	cify Yes or No- Rican, etc.)	14. Ra Bla	ce - Ameri ick, White,	can Indian, etc.			
Ϋ́F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	1	I∐Yes 2∭ No <i>Speci</i>	fy:		Specia	fy: 5.7h	ite			
b b		16a Daga	Jant's Lloyal Occupation			16b. Kind of E					
Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done during m DO NOT use retired)	ost of workin	ng	100. Killa of E	ousiness/in	idustry			
Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)		omemaker				own h	ome			
ပ္	17. Father's Name (First, Middle, Last)		18. Mot	ther's Name	(First, Middle,	Maiden Surnai	me)				
To B	Revere Babcock Gurley		Ma	argare	t Carri	ington					
F	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ng Address (Street and Num				n. State. Zii	p Code)			
	Scott Frederick Mattern - son		Bluff Terrace			ing, M					
	20a. Method of Disposition 20b. Pla	ice of Dispos	sition (Name of natory or other place)	Da	ate	20c. Location	- City or To	own, State			
	I MU buriai 2 Li Cremation 3 Li Hemoval Ironi State I		ew Cemetery	08/10	/09	Warren	ton	VΔ			
	21. Signature of Funeral Service Licenses		. Name and Address of Fac	cility Mo	ser Fur	neral H	ome,				
	23a. Furt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
iner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause, (Disease or injury)  Due to (or as a consequence cause).		Interval Between Onset and Death								
edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	ence of):									
Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			- 1	ate of deliv	very Day Year			
ed by P	Part II. Other significant conditions contributing to death but not result	ting in the ur	nderlying cause given in Par	rt I.				the cause of death?			
Comple					24a. Was a autop perfor 1 □ Yes		Were auto prior to co death? 1 🗆 Yes	opsy findings available ompletion of cause of 2 No			
Be	25. Was case referred to medical examiner?		0.0		(Check only or						
		R/Outpatien						<sub>ify)</sub> Hospice			
o	1 🛣 Natural 5 🗆 Pending (Month, Day, Year)	28b. Time of Injury	Work?		ಚರ. Describe h	ow injury occu	rred				
cat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of Injury - At box		M 1 □Yes 2		not 11 co						
Medical Certification: To	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, iarm, stre	вет, настоту, опісе	2	281. Location (S City or Tow	ureet and Num n, State)	ber or Rur	al Route Number,			
Č E	29a. Certifier 1  Certifying Physician: To the best of my know	ledge, death	n occurred at the time, date	and place.	and due to the	cause(s) and n	nanner as	stated.			
dic	(Check only one) 2 Medical Examiner: On the basis of examinati and manner stated.										
Me	29b. Signature and title of certifier		29c. License numbe			29d. Date sign	ed (Month,	Day, Year)			
	J. Kouelt cheu		D637L	18		Aug.	5, 2	2009			
	30. Name and address of person who completed cause of death (Item Jocelyne Kouatchou, MD 201	E. Un	iversity Pkw	y Balt	imore.						
e	31. Date filed (Month, Day, Year)  AUG 10 2009	par	led	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death **Physician** Charles Lee Niblett 26, 2009 4c. County of Death 0216 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rehabilitation & Nursing Ctr Salisbury Wicomico 15 burg Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 3, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 84 Feb. 215-26-5580 1925 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 2118 Ruxton Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ould be filed within 72 hours after Mental Hygiene. 1 ☐ Never Married 2 X Married 21215-0036 1 ☐ Yes 2 🛣 No 1946 Specify Completed by Specify. 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Home Construction Carpenter Is marked other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evones. Ross Morris Agnes Niblett ျှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Winifred L. Niblett/Wife 2118 Ruxton Drive, Salisbury, Marylent 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Crematory of Delmarva 7/27/2009 4 Donation 5 Dother (Specify) Delmar, Delaware 22. Name and Address of Facility Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury 21. Signature of Experal Service Intenses MD 21802 Approximate Interval Between Onset and Death Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ear 70> /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to him collate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Quality for as a consequence of: the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this After this funeral o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 5 Pending within 24 hours after oean.

To the Funeral Director: Af 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar illiam

31. Date filed (Month, Day, Year)

JUL 29

S

Q

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Begistrar's Signature

H: Robins

D29349

200 Civic Ave. Salisbury, MD 21804

July 27, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician**  $\mathbf{p}^\mathsf{M}$ Richard J. O'Rorke, Jr. 25, 3:17 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year)
Aug - 27, ] If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F Director 217-32-4040 72 1936 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 X No Director Maryland Montgomery Bethesda 10e. Street and Number 10g. Citizen of What Country? 9308 Parkhill Terrace 20814 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: White 1 ☐Yes 21 No þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Economist Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be file of Health and Mental Hi fitem 27 Is marked oth r other traumatic event Be Richard O'Rorke Janet Otterbein 19a. Informant's Name/Relationship (Type. Print) (daughter) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith O'Rorke-Trigiani 3704 Emily Street, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. July 29 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 2009 21. Signature of huneral Service Licensee Francis J. Schillins Funeral Home Inc. Halen 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** trterioscle notic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of) Completed by Physician/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Ceath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

25/09 3:17 pm o Records, Vital Hospital or Attending Physician: of Division

filled in by the funeral director, 24 hours after deat Funeral Director: within 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) somery Physician

George town Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State

2

Medical

			1 - For State Registrar	Otate of W	ar ylaric		rtificate of	Death	•	Reg. No. 2	09	25446
	Physici	an	1. Decedent's Name (First, Middle		OTT O CIT	A			2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		LOVEDAY		OKOCHA	A			JULY		009	8:35 A M
	Examin	er	4a. Facility Name (If not institution	-				or Location of Death	1	4c. County		V
and the			WASHINGTON  5. Social Security Number	ADVENTIST H	OSPITA ge (In yrs. la		TAKOM If Under 1 Year	A PARK  If Under 24 Hrs.	9 Date of Birt		GOMER	.Y lace (State or Foreign
	Funeral Director		234-25-7208 Usual Residence of Decedent	1 ☑ M 2 □ F	55	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da) JULY 1	y, Year) 5 1954	NIGE	itrv)
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f sh	ţċ	MD PRINCE	GEORGE'S	GR	EENBEI	T					1. Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	itry?
	th wil	la l	9210 SPRINGHILL	LANE # 202			20770			USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. If where I is a nine must be in official and once.	Completed by Funeral	11. Marital Status 1 ☐ Never Married 2∏ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □Yes 2 ☑ If Yes, Give Year or Dates:	?		Nas Decedent of I fYes, specify Cub I □Yes 2ឦNo	Hispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Ra Bla Specii	ce - Americ ck, White, e fy: BL	
2-0	72 ho natur	etec	15. Decedent (Specify only highes	's Education	Ţ	16a. Dece	dent's Usual Occup	pation	kina	16b. Kind of B	usiness/Ind	dustry
2	ithin ne.	ld m	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use retire AGER	during most of word d)	w/g	PRIVAT	Έ	
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and	l be fi	Be	17. Father's Name (First, Middle, I	,				18. Mother's Nam	AKWZOR	Maidell Sullial	ne)	
2	ihould nd Me mark matic	မ	DANIEL OKOCHA  19a. Informant's Name/Relationsh			19h Mailir	na Addraes (Straat	and Number or Ru		ar City or Town	Stata Zin	(Code)
Ma	nd 2 s Ith ar 27 Is 1 trau		CHRISTINA OKOC									LAND 20770
ē,	s t ar f Hea item (		20a. Method of Disposition		20b. Pia	ace of Dispo	sition (Name of natory or other pla		Date	20c. Location	- City or To	wn, State
E O	Page ient o nt: If ry or		1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			ILY PI		8/10	/2009	PORTHAC	OURT,	NIGERIA
Baltimore, Maryland 21215-0036	permit. Departm Importa any inju		21. Signature of Furieral Service I	• • • • • • • • • • • • • • • • • • • •	- S		. Name and Addre	ess of Facility	J. B. J	ENKINS	FUNE	CAL HOME
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68760,	cate b	Medical		d. CEIL	Chi	UVH	SCULA	K ALCO	7(1)(3)(			
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ To 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3 🗆	Ectopic pregnand Other (specify)	су			ate of delive	ery Day Year
α <u>.</u>	s that ned by deta	by Ph	Part II. Other significant conditio	ns contributing to death b	out not resul	ting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	obacco use con	tribute to th	ne cause of death?
ğ	quires	q pe	HYPERL	CENNON	<u>/                                    </u>				1 □ Y	es 2 No	3☐ Prob	ably 4 Unknown
Records,	e law requir has been si e 2 should I	Completed							24a. Was a		Were auto	psy findings available
Ě	The I	E O							autop perfor 1 □ Yes	rmed?	death?	mpletion of cause of 2 ⊒ No
<u>ta</u>	sician: The certificate hi	Be	25. Was case referred to medical examiner?					26. Place of Dea				
<u>&gt;</u>	Physic this co	P	1 Yes 2 ₹No	Hospital: 1 ☐ Inpati	ent 2□E	R/Outpatien	t 3 □ DOA Oth	ner: 4 🗆 Nursing H	ome 5 ☐ Resid	dence 6 □Ot	her (Specif	(y)
n	ding Ph h. After thi funeral	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		ury a <i>y, Year)</i>	28b. Time of Injury	Wor	'k?	28d. Describe h	now injury occur	red	
S	Attend death ctor: / y the f	icat	2 ☐ Accident investigation in	ot be	iun. At hon	no form of		]Yes 2□No	DOL Location (C	Na 4 4 6 forms	h = u = u D	( Davida Alexandra)
Division of Vital	al or Attendi s after death.	Certification:	4 ☐ Homicide determi	ned building, et	c. (Specify)	ne, iann, sin )	eet, factory, office		City or Tow	otreet and Num vn, State)	oer or Hura	l Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (	29a. Certifier 1 ☐ Certifying (Check only one)	g Physician: To the best Examiner: On the basis of and manner st	of examinati	rledge, death on and/or in	n occurred at the tivestigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	nanner as s and due to	tated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signe	ed (Month,	Day, Year)
	4		* SAMAN	lun			D-	-54286	7	07/2	25/2	2009
	20		30. Name and address of person v	who completed cause of c	death (Item	23a) (Type,	TON A	)VENII1	WOLP,	TAMO	mpt (	ner
ı	Sta Registra		31. Date filed (Month, Day, Year) 1111 2 8 2009	32. Registr		ye ares			,		MD-	20912

Examiner Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninar must be notified at aprice. Be Completed by Funeral Director Baltimore, Maryland 21215-0036 2 Physician /Medical **Examiner** Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician /Medical

	Plea		•					Ensure /				gible.		
For State Registrar		7	state of ivia	aryiani		ertifica		lealth and Death	Wella		g. No. 2	009	9 2	544
1. Decedent's Nam									2. Date Mor	e of Death	Day	Year	3. Time	of Death
Evelyn	June	е	Poole							ıly	16,	2009	12	:30P™
4a. Facility Name (	If not institution	n, give stre	eet and number)			4b. Cit	y, Town, o	r Location of Dea	th			nty of Deati		
Crofton							Cro ler 1 Year	ofton   If Under 24 Hrs	S I o Date	of Pirth		e Aru	hplace (State	e or Foreign
5. Social Security N 235-28-1		6. Sex 1 ☐ N	/ 2 □ <b>X</b> F / . Ag	e (In yrs. la 86		Month		Hours Min	. (Mo.	of Birth	Year)	Co	untry)	
Usual Residence o				- 00					May	<u>7 16,</u>	1923	wes	st Vir	JIIIIa
10a. State	10b. County			10c. City	, Town o	r Location							10d. Inside	•
MD	Prince	e Geo	orge's					Bowie					1. <b>A</b>	es 2 No
10e. Street and Nu	mber					10f. 2	Zip Code			10	g. Citizen	of What Co	untry?	
13930 We	stview	Fore	est Drive	е			207						SA	
11. Marital Status			. Was Decedent I Armed Forces?		3.	13. Was Dec If Yes, sp	cedent of F pecify Cub	lispanic Origin? ( an, Mexican, Puei	Specify Year to Rican, e	s or No- etc.)		Race - Ame Black, White	rican Indian, e, etc.	
1 ☐ Never Marr 3 ☐ Widowed		ied	1 ☐ Yes 2 ☑ 1 If Yes, Give Year or Dates:	No		1 ☐ Yes	2 🛛 No	Specify:			Spe	cify: W	hite	
3 Managamed	15. Decedent	t's Educat		Т	16a. D	ecedent's U	sual Occur	ation		1	6b. Kind of	Business/	Industry	
	cify only highes		completed)		10		vork done	during most of wo	orking					
Elementary/Seco	ondary (0-12)		College (1-4or 5	)+)		Admin	istra	tive				Hospi	tal	
17. Father's Name	(First, Middle,	Last)						18. Mother's Na						
Orbie	e Virgi	il N	<i>l</i> oye					Ma	mie	Ruth	Sur	face		
19a. Informant's N	lame/Relations	hip <i>(Typ</i> e	. Print)		19b. N	lailing Addre	ess (Street	and Number or F	Rural Route	Number,	City or To	vn, State, Z	Zip Code)	
Randall		Son						all Driv			-			
20a. Method of Dis 1 ☑ Burial 2	,	3 □ Ber	noval from State			isposition (A crematory o			Date				Town, State	
	5 Other (S			Woo	xdlaw			Park 7/	/18/20	009	Bluew	ell,W	est V:	irgini
21. Signature of	uneral Service	Lieensee				22. Name	and Addre	ess of Facility	Beal:	l Fun	eral	Home		
16	< 1-					6512	NW C	rain Hwy	Z.Bov	wie,	$MD_20$	1715	Approxin	
23a. Part 1. Enter shock, or hea	art failure. List	only one	cause on each li	ne.	i. Do noi	t enter the ri	loae or ayı	ng, such as cardia	ac or respir	alory arre	St,		Interval E Onset ar	Between
Immediate Cause disease or condition resulting in death)	on	a	Cono	rest	in	e H.	ear	t Fail	eru				yea	ص
, and the second of			Due to (or as	•	- 0	n r	. L.						0	
Sequentially list co	onditions,	b	Due to (or as		Jence of)	July	au	ion	_				yea	00
Cause (Disease of	erlying r injury	8	Car	مناه	m.	MAN	210	11					Won	C& 4
that initiated event resulting in death)	Last	Ç	Due to (or as	a consequ	uence of)	00		7					0	
		Cd.												
IF FEMALE:		T												
23b. Was deceder		230	<ol> <li>If yes, outcome</li> <li>1 ☐ Live birth</li> </ol>			3 ☐ Ectopi	c pregnan	су			23d.	Date of del	livery Day	Year
in the past 12 1 ☐ Yes 2 9 ☐ Unknowr	No		4 ☐ Pregnant a 9 ☐ Unknown	t time of d	eath	5 Other	(specify) _					141011111	Day	1001
Part II. Other signi		one contri	ibuting to death h	ut not ree	ulting in th	ne underlyin	a cause air	ven in Part I	23	e. Did toh	acco use c	ontribute to	the cause of	of death?
Tartii. Other signi	meant condition	one contra	ibating to death b	di noi rese	aning in a	io dilacityiii	g ouddo gi	on in rait is		1 □ Ye			robably 4[	
									-	- 18/			d dinalin	
									- 24	<ul> <li>a. Was an autopsy perform</li> </ul>	/	prior to death?	utopsy findin completion o	of cause of
05.114										Yes 2	<b>⋈</b> No	1 ☐ Yes	2 □ No	
25. Was case refe examiner?	rred to medical €No		spital:	opt 1	ED/Outo	atient 3 🗌	DOA Otl	26. Place of Dener: 4 Nursing				Other (Spe	- if i	
27. Manner of Dea			28a. Date of Inju	ıry	28b. Tin	ne of	28c. Inju				w injury oc	, ,	city)	
1 XNatural 2 ☐ Accident	5 ☐ Pendin investig	g gation	(Month, Da	y, rear)	Inju	M M		rk? ]Yes 2 □No						
3 ☐ Suicide 4 ☐ Homicide	6 Could determ		28e. Place of Inj building, et	ury - At ho	me, farm	n, street, fact	ory, office		28f. Loc	cation (Str	eet and Nu	ımber or Ri	ural Route N	umber,
4 [] Hornicide			building, co	o. (opcon)	,,				On.	y 01 101111	, Olalo)			
29a. Certifier (Check only one)				of examina		or investigat	ion, in my	ime, date and pla opinion, death oc						e(s)
29b. Signature and	d title of certifie	r			. 4 0/1			se number		29	d. Date sig	gned (Moni	th, Day, Year	)
m	00 :. 0	m	14000	490	10		RA	68 HQ=	5		2.1	u 17.	am	19
30. Name and add	Iress of person	who com	pleted cause of c	leath (Item	23a) (T	ype, Print)	willi	E Jarre	II.CR	NP	0	9,0	1 200	
143000	calla.	at F	fox ha	ne.	Su	itea	22	Bow		Nari	lan	d a	0715	
31. Date filed (Mo	oth, Day, Year)	2000	2. Registr	ar's Signa	ture						1			
JU	LAUZ	2009	Status	r [7].	A	ares								

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			1 - For State Registrar	Otate of Marylar		rtificate of			g. No.) ( ( )	251.1.8		
	Physici	an	1. Decedent's Name (First, Middle, La	•				2. Date of Death Month		3. Time of Death		
1	/Media			Bismarck		Pinkne		Month 7/1		1350P <sup>M</sup>		
	Examir	er	4a. Facility Name (If not institution, given			4b. City, Town, or Location of Death			4c. County of Death			
-	Funeral		Prince George  5. Social Security Number 6. S	Sex 7. Age (In vrs.	last birthday)	Cheve If Under 1 Year	erly If Under 24 Hrs.	8. Date of Birth	Prince 9. Bir	George thplace (State or Foreign		
	Director		214-42-2914 Usual Residence of Decedent	<b>™</b> 2□F 66	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 6/11/	1943 Was	hingtonDC		
	/land		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits		
	a-fsh	ctor	Maryland Princ	e George C	apito	l Heigh	nts			1 □ ¥es 2 □ No		
	or 28	Jire	10e. Street and Number	0 0001901		10f. Zip Code		10	g. Citizen of What Co	ountry?		
	ath wi	ral	5914 Addison	Rd			743		USA			
	er de	Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White			
36	irs aft		1 XNever Married 2 Married 3 Widowed 4 Divorced	1 ⊠Yes 2 □ No1 9 6 If Yes, Give Year or Dates: 1 9 6 5		1 □Ye <i>s</i> 2 <b>%</b> No	Specify:		Specify: To 1	م ماد		
9	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show deal Eventher must be redfied at	Completed by	15. Decedent's E	ducation	16a. Deced	dent's Usual Occu		16	6b. Kind of Business	ack (Industry		
21	ithin 7 ne. nan "r	nple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire	during most of word d)	king				
121	Hygier Hygier Her th	S	12 17. Father's Name (First, Middle, Last		S	killed			Construc	tion		
ano	d be f ental l sed of	Be c		,				ne (First, Middle, Ma				
ary	should nd Me mark nmark	은	Carlos  19a. Informant's Name/Relationship	Type. Print)	Pink	ney ng Address <i>(Stree</i> )	Katie  and Number or Ru	ral Route Number.	Pinckr City or Town, State	Zip Code) 20772		
Ž	s 1 and 2 soft Health a item 27 Is		Delores P. Smi		13507	Old Ma	rlhoro	Dika Unr	per Marl	20772		
e,	of He of He item		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other pla	ce)	Date 20	oc. Location - City or	Town, State		
<u><u>ĕ</u></u>	Page ment ant: If ury o		1  Burial 2  Cremation 3  C 4  Donation 5  Other (Special					/2009 Ch	neltenha	m,Maryland		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglone. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventher runt be refified at once.		21. Signature of Funeral Service Lice	1606	22	. Name and Addre	ess of Facility					
			Aguasco I									
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.			343	,	7	Approximate Interval Between Onset and Death		
	/Medical	resulting in death)  a. Tacal Call Till Till Call Till Till Call Till Till Till Till Till Till Till T										
	Examiner		Sequentially list conditions	b. Caridiop	ulmon	ary Arr	est					
	ed sit	iner	Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a sonseq	uenee or):				· ·			
_	xecut and Il-tran	хаш	that initiated events resulting in death) Last	c Due to (or as a conseq	neace of).							
68760,	rtificate be executed ng physician and as the burial-transit	Medical Examiner		d								
687	tificate g phy as the	ledic		0.								
Вох	th cert		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	20.4		23d. Date of de	livery		
О Ш	res that the death ce signed by the attendi be detached for use	Physician/	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of c		Other (specify)			Month	Day Year		
σ.	that the post of t		Part II. Other significant conditions	ontributing to death but not resi	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?		
Division of Vital Records,	quires en sigr uld be	ed by	Anoxic_Er	cephalopath;	У			1 ☐ Yes	2 <b>1</b> No 3 □ Pi	robably 4 🗆 Unknown		
ဝင္ပ	law re as be 2 sho	Completed						24a. Was an	24b. Were at	utopsy findings available completion of cause of		
<u> </u>	ding Physician: The h. h. After this certificate h. funeral director, page	E O						autopsy performe 1 □ Yes 2	ed? death? ZNo 1 ☐ Yes	2 □No		
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Heesitel - /		100		th (Check only one)	! —			
ot	Phys	P.	1 ☐ Yes 2 2 No 27 Manner of Death	Hospital: 1 Inpatient 2   28a. Date of Injury	ER/Outpatien 28b. Time of		4 LI Nursing H		ce 6 ☐ Other (Spe	cify)		
o	th. th. the Afte	tiol	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wor	k? K? Yes 2□No	28d. Describe how	injury occurred			
Visi	Atter	ifica	3 Suicide 6 Could not b		ome, farm, stre			28f. Location (Stre	et and Number or Ru	ural Route Number,		
	ital or rs afte al Dir led in	Certification:						City or Town,				
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Medical	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	yslcian: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the ti estigation, in my	me, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner as e and place, and due	s stated. e to the cause(s)		
	To th within To th comp	Me	29b. Signature and title of certain	17		29c. Licens	se number	290	d. Date signed (Mont	h, Day, Year)		
			The state of the s			D64	1478		07-21-09			
6	n		30. Name and address of person who			Print)						
	X) ();		DR.Fisehatsi	on Mehari, 30 32. Registrar's Signa	01 Ho	spital	Dr.Chev	erly MD	20785			
I	Sta Registra	ie ar	31. Date filed (Month, Day, Year)	2009 Seneur	B. 4	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7/21/2009 9:03p M Catherine Pinkney /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George Upper Marlboro 13009 Van Brady Rd If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9 / 21 / 1 912 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** 1 □ M 2 1 F Days Min Washington DC Yrs. Director 96 213-38-2096 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George Upper Marlboro 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? filed within 72 hours after death with the Hygiene. ō items 23a 13009 Van Brady Rd 20772 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 24 No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or Completed by 1 ☐ Yes 2 🕱 No Specify: Specify Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) ∄dge Meade School Teacher-Aide is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any linity or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Ida Tomes 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13009 Van Brady Rd, Upper Marlboro MD 20772 Myrtle Jones/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/09 Upper Marlboro MD St.Simon Cem. 22. Name and Address of Facility Adams Funeral Home, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CAD, COPD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PVD, Sequentially list conditions, if any, leading to immediate cause. Enter the children of Cause (Disease or injury that initiated events Completed by Physician/Medical Examiner Due to (or as a consequence of) ul or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and DM, CMF, HTN Hyperlipedemice burial-trar resulting in death) Last Due to (or as a consequence of): the use as t attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a I be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 1 □ Yes 2 No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Hospital c 24 hours af e Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

within 2.

one) 29b. Signature and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUL 27 2009

tch: nson

32. Registrar's Signature

Baltimore, Maryland 21215-0036

P.O. Box 68760.

of Vital Records,

29c. License number

0059693

Branch Ave Vergle

29d. Date signed (Month, Day, Year)

Amend #5, per Fh g895 9/3/09 TT / Department of Health and Mental Hygiene For State Registrar Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 2009 Αм 1:20 Dorothy G. Rhoderick August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Homewood at Crumland Farms Frederick Frederick 5. Social Security Number 0767 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 86 Director Maryland 218-12-<del>0764</del> October 9. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, trains item for items of continuents 1 □Yes 2X No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 United States 7341 Willow Road. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 💢 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo þ If Yes, Give Year or Dates: Specify. White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 12 Cashier Restaurants 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Stewart A. Geisbert Naomi Phebus ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Health a Department of Health Important: If item 27 any injury or other tr 1008 Winding River Lane, Phoenixville, PA 19460 Mahlon E. Rhoderick, Son Saltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) August 5. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland Keeney and Basford PA Funeral Home, 106 E. Church Street, Frederick, Maryland 21701 of Funeral Service Lie 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) (01-612010) /Medical Due to (or as a consequence of) Examiner Extinsive Sequentially list conditions if any loading to in roduct cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Tyes 2 No o the 9 Unknown as been signed by the should be detached ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed' certificate 2 No 2 No 1□Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 W Naturai 5 Pending thin 24 hours after death.

the Funeral Director: A
mpletely filled in by the fu death. 1 ☐ Yes investigation 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MB 50 31. Date filed (Month, Day, Year) Registrar's Signature 32. State AUG 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DIL

09-06011 Geoffrey Sutherland

# Plea

nd #State of Maryland P.Bepartinent of Aear	And Mental Hygiene	2545
Certificate of Death	Reg No.	- 0 7 0

		For State		f Death									
Physician ledical Examine	/ 1	Decedent's Name (First, Middle,Last) Geoffrey Donald	Sutherlan	ıd			A.	Pate of Death Month Daugust 1, 20	09	3. Time of Death 2135 hrs			
	4	a. Facility Name (if not institution, give a 7905 Clover Hill Drive	street and number)		4b. City, Town, o	or Location of	Death		4c. County of Frederick				
Funeral Director	5	6. Sex 579-74-0871 6. Sex	7. Age (In	yrs. last birthday) 9 Yı	If Under 1 Ye Months Da		Min	Date of Birth (I	мм/DD/YYYY) 0, 1949	9. Birthplace (State or Foreign Country) Australia			
th the Maryland 23a or 28a-f show any notified at once.	1 5 2	Jsual Residence of Decedent  10a. State 10b. County  Maryland Frede:	rick	c. City, Town or Loca	Frederic	:k 			Citizen of Wha				
th th		7905 Clover Hill Drive  11. Marital Status  1 X Never Married 2 Married	12. Was Decedent Eve Armed Forces?	lf	as Decedent of F Yes, specify Cub.	lispanic Origi an, Mexican,	y Yes or No-	14. Race - White,	American Indian, Black, etc.				
5-0036 led within 72 hours after death wi Yegiene. other than "natural", or items the Medical Examiner must be	ompleted by r	3 Widowed 4 Divorced 15. Decedent's Education (Specify only Elementary/Secondary (0-12)	f Yes, Give Year or Dates: / highest grade comple College (1-4 or 5+)		Yes 2 X Nent's Usual Occup most of working li	ation (Give ki		done 1	Specify:  6b. Kind of Bus  couries				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Re Com	17. Father's Name (First, Middle, Last)  Donald Norman Su	st, Middle, Mai Sutherla	iden Surname)									
MD 21216 d 2 should be fill lth and Mental H n 27 is marked of tumatic event, to		19a. Informant's Name/Relationship (Ty Alan Sutherland ,	pe, Print )		ng Address (Str Overlook			ick, Mar	yland 217	n, State, Zip Code) 702 City or Town, State			
ore, slan of Hea If iter		4 Donation 5 Other Specify:	crematory or other place)  Smithsburg Crematory  August 6, 2009										
Baftimo permit. Page permit. Page Department. Important: injury or ott		23a. Part I. Enter the disease, or compli	Signature of Fundamental Address of Facility Keeney & Basford P.A. Funeral Home 106 Fast Church Street, Frederick, Maryland 217  a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										
/Medical xaminer			h line. <b>Hypertensi</b> v ue to (or as a consequ		sclerot <del>sleeoti</del> e	ic cardi	iovasc	cular d	<u>isease</u>	Between Onset and Death			
ed ssit	mine.	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequ	ence of):									
760, icate be execut physician and the burnal - tra	Medical	/Medical	//wedical	IF FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	AMENDED #3, g895, 23c. If yes, outcome  1 Live birth 4 Pregnant at tirr	of pregnancy	r ME g89 lhb Fetal death Other (Specify)				23d. Date of Month	delivery Day Year	
P.O. Be es that the de igned by the de detached f	<u>a</u>	Part II. Other significant conditions		ut not resulting in the	e underlying caus	e given in Pa	art I.			bute to the cause of death?  Probably 4  Unknown			
Division of Vital Records, lat or Attending Physician: The law requires rs after death.  In Director: After this certificate has been sighted in by the funeral director, page 2 should be a should be	Completed							24a. Was ar autops perform 1 Yes 2	y p	Were autopsy findings available brior to completion of cause of leath?  Yes 2 No			
tal F	Be	25. Was case referred to medical examiner?	penital			ace of Death				4.04			
n of Vit ding Physic After this	1 Ves 2 No 1 Impatient 2 Er/Outpatient 3 DOA 4 Notice of Injury 28b. Time of Injury 128c. Injury at Work? 28d. Describe how injury occurred												
Division To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	e 28e. Place of Injur	y - At home, farm, si				or Town, Sta		er or Rural Route <b>N</b> umber, City			
To the Hosp within 24 ho To the Fune completely f	<u></u>	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	an: To the best of my k On the basis of examinand manner stated.	nowledge, death oc nation and/or investi	gation, in my opir	ion, death oc	ace, and du ccurred at th	e to the cause ne time, date a	nd place, and d	lue to the cause(s)			
		29b. Signature and title of certifier  Aumeh Just	all mo			29d. License number 29d. Date signed (Month, Day, Year)  O.C. M.E. August 2, 2009							
_		30. Name and address of person who o Pamela E. Southall, MD	ompleted cause of dea Assistant Medica		111 Penn Str	eet, Baltin	nore, MD	21201					
Sta Registr	_	31. Date filed (Montri Day: Year)	32. Registrar's	Signature	and of								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 2-00 AM Eleanore Stacherski July 27 2009 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Days Months Director 371-14-0213 87 October 10 1921 Michigan Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examination to retilied at 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** Md. 1 ☐ Yes 2√2 No Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 60 Orpah Drive 21921 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line 12 General Motors marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) les 1 and 2 should be file of Health and Mental Health and Mental Health arked oth filem 27 Is marked other traumatic even Be Frank Makowski ပ Mary Blindowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Kenneth Stacherski, Son 60 Orpah Drime Elkton, Md. 21921 Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
R. A. Ferris &Co. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. 17-28-09 West Chester, Pa. 22. Name and Address of Facility 259 E. Main St., Andrew G. Gee F. H. Elkton, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) nsutc /Medical Due to (or /s a consequence of): Examiner econder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last to (or as a consequence of): Fen and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Hospital or Attending Physician: The 805 performed Division of Vital 1 □Yes 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 □ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 D Natural 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b, Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) Lak and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - State of Maryland / [		artment of Hertificate of L		ind Me		ene	19	254	53
	Physici	an	Decedent's Name (First, Middle, Last)				1	<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of	
	/Medic		Doris Butler Van Swaringen					July 1		009	7:30	A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or				4c. Count	-		
			3530 Patuxent River Road  5. Social Security Number 6. Sex 7. Age (In yrs. last bir	*******	Dan If Under 1 Year	Vidso		LC B. Date of Birth	Anne	Anne Arundel  9. Birthplace (State or Foreign		
	Funeral Director		4 DM OFF	rnday) Yrs.	Months Days	Hours	Min.	(Month, Day,	Year)	Cou	intry)	roreign
H.		- }	Usual Residence of Decedent					May 17	, 1924	\	ginia	
	yland	Ì	10a. State 10b. County 10c. City, Tow	n or Lo	cation						10d. Inside Cit	y Limits
	e-f s	io	MD Anne Arundel		Da	vidso	nvil]	le			1 🗌 Yes	2 <b>%</b> No
	or 28	Director	10e. Street and Number		10f. Zip Code			10	g. Citizen of	What Cou	intry?	
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	r dee	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cubar	spanic Orig	jin? (Spec , Puerto R	ify Yes or No- ican, etc.)		ce - Amer	ican Indian, , etc.	
50	or li	by Ft	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 9 Year or Dates:		1 ☐ Yes 🏖 No	Specify:			Speci	fy: Tv	hite	
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9	e filed within 72 hours after death with the Maryland if tygiene. other than "natural", or flema 23a or 28e-f show other than "natural", or flema 23a or 28e-f show vent, the Medical Examene must be notified at	0	17. Father's Name (First, Middle, Last)			18. Mother	r's Name (	(First, Middle, M	faiden Suma	me)		
	Henta Henta rked	To B	Jack Butler			Dor	is Ma	arguerit	e Tucl	ker		
Mary	and N		19a. Informant's Name/Relationship (Type, Print)	. Mailir	ng Address (Street a	nd Numbei	r or Rural	Route Number,	City or Town	, State, Zi	p Code)	
≥ .~	and alth		Doris E. Petitti/Daughter		04 Greer	Court		-				
e O	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Menth Hygiene. Department of Health and Menth Hygiene.  Brownstent: If them 27 is marked other than "natural; or fleme 23a or 28e-f show eny injury or other traumatic event, the Madical Examiner must be notified as once.		1XI Burial 2 Cremation 3 Removal from State	ry, crer	sition (Name of natory or other place		Da		Oc. Location			
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20	permit Depar Impor Impor ony in		21. Signature of Funeral Sarvice Licensee		. Name and Address		100	eall Fur				
	40200		23a. Part1. Enter the disease, or complications that caused the death. Do		6512 NW C					0715	Approximate	
			shock, or heart failure. List only one cause on each line.								Interval Betw Onset and D	reen
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	Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Chronic Obstr.  Due to (or as a consequence b. Coronary Ary A	01):	210 N:	r a 1	-0				14 y	2 4 4 .
	Z 24)	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		crei pi	V CPT	J C				11-7	au
	cuted nd ransii	Examiner	that initiated events C.									
00,	cate be executed bhysician and the burial-transit	EX	resulting in death) Last Due to (or as a consequence	of):								
0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d									
0 X	w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Med	IF FEMALE: 23c. If yes, outcome of pregnancy									
2	atten for us	lan	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death		Ectopic pregnancy Other (specify)					ate of deliventers		ea <i>r</i>
j	the d	ysic	1 Yes 2 No 9 Unknown 9 Unknown	3	Other (specify)							
ŗ	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in	n the ui	nderlying cause give	n in Part I.		23e. Did tob	acco use cor	tribute to	the cause of de	ath?
cords,	quires n sign	ed by						1 🗗 Ye	s 2 No	3 □ Pro	bably 4 ⊟U	nknown
2	s been si should	lete						24a. Was an	24b.	Were aut	opsy findings a	vailable
ב	vician: The lav certificate has rector, page 2	Completed						autopsy	ed?	prior to death?	ompletion of ca 2□ No	use of
	Physician: The this certificate har al director, page	0	25. Was case referred to medical			26. Place	of Death /	1 ☐ Yes 2 Check only one	No No	1 1 105	2 110	
>	Physician: r this certifica ral director,	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Ou	tpatien	t 3 DOA Othe	r: 4 🗆 Nur	sing Hom	e 5 PResider	nce 6 □Ot	her (Spec	fy)	
5 =	ding Pt h. After tt funeral			Time of	28c. Injury Work	at	28	3d. Describe ho	w injury occu	rred		
2	endi eath. or: A the fu	catle	2 Accident investigation			es 2□N	40					
<u> </u>	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	m, str	eet, factory, office		28	If. Location (Str. City or Town,		ber or Rui	al Route Numb	er,
3	pital urs a erel [		200 Contilion 1 Total Charles To the boat of much and a				-					
	Hoa 24 ho Fun stely f	edical	29a. Certifier  (Check only one)  1. Certifying Physician: To the best of my knowledge  2	d/or inv	estigation, in my op	e, date and inion, death	h occurred	id due to the ca d at the time, da	use(s) and m te and place,	anner as	stated. to the cause(s)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Me	29b. Signature and title of certifier	una	29c. License				d. Date sign			
	- > PO 0		A. Stephen HANGMAN A.	10	D27	138	8	54 5	TULY	15	2009	
	.,		30. Name and address of person who completed cause of death (Item 23a)	(Туре,	Print)		2	,	-,,	7		
	8W		30. Name and address of person who completed cause of death (Item 23a) of A. Stephen Hansman, 13.7 Mit  31. Date filed (Month, Day, Yaar)  32. Registrar's Signature	ch	ells Chi	ANCE	2 Roll	7180, E.	dgewi	4Tex	MDZIC	37
	Sta	te	31. Date filed (Month, Day, Year) 2009 33. Registrar's Signature	1.	41							
	Registr	all'	COUL TOUR CEMENT A. I	W K	Car.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G894 8/25/09 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6630M VINCENZA SPARANO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLTS
If Under 1 Year | If Under 24 Hrs. | ANNE ARUNDEL (State or Foreign <sup>5. S</sup>**08** <u>3 сорту Митр 28</u> 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace Country) **Funeral** 1 □ M 2 □ F Months Days Hours Min. 96 Director New York 4-5-1913 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Exactions or other traumatic event, It. Medical Exactions. 1**▼**Yes 2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21403 U.S.A. 207 President Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Jacobi Elementary/Secondary (0-12) College (1-4or 5+) Hospita1 Receptionst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tricarico Ernesto Caterina Cannelongo ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Nolan 207 President Street Annapolis, Md. 21403 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 urial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Raymond Cemetery 7/18/2009 Bronx, New York 22. Name and Address of Facility 21. Signature of Funeral Service Licenses John Dormi & Sons Funeral Home 1121 Morris Pk. Avenue Bronx, New York Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a 9 Unknown signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been si r, page 2 should t 1 🗌 Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 1 □Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA မှ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After t Certification: Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the lawithin 2 and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar Name and address

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Y **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**X** F Hours Min. Yrs. 90 Director 218-37-2433 May 05, 1919 Belarus Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5801 Nicholson Lane, #210 20852 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Ď Specify. 3 ■ Widowed 4 □ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Bookkeeper Financial Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rochel Berman ပ Morduch Sprishen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2343 Deckman Lane, Silver Spring, Maryland 20906 Aida V. Gopstein - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 07/24/2009 Clarksburg, Maryland Garden of Remembrance 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the dis as shock, or heart failure: Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: fyes, outcome pf pregnancy □Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 pronths?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 Live birth Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 1 Watural 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director:

> geath from 23a) (Typol Pipe) TRUSERUAD, RECKVILLE, MD 20852 31. Date filed (Month, Day, Year) State 27 2009 Registrar

29b. Signature and title of centifier

29c. License number D 35436

29d. Date signed (Month, Day, Year) JULY 23, 2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month ASADALLAH 2009 SOLEIMANIFAR JULY 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Min. 1**X** M 2□ F Yrs Director 3/21/1925 84 Isfahan 578-11-9693 Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at T¥TYes 2∏No Directo Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5909 Ipswich Road 20814 United States 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 6 7(25/09 1005 Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Iranian Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Private Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Gasem Soleimanifar Mohtaram Soleimanifar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 is Zoya Soleimanifar / Daughter 5917 Ipswich Road Bethesda, Maryland 20814 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 😾 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/4/2009 Bagherezvan Isfahan 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee M00981 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease, or complifations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician a consequence (f): /Medical chest waller Arm Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 by Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed

The law requires that the death certificate be executed of Vital

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Hospital or Attending Physician; after death.

Director: After this certification by the funeral director, 24 hours a

Be

Certification: To

Medical

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

completely filled To the I within 2

State Registrar

DHMH 17 Rev 1/2001

Sima Nourani- Zernuz 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 Could not be determined

8600 Old Georgetown Rd. Bethesda, Maryland 20814 32. Registrar's Signature

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

2 **55**No

1 □ Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2 **X** No

28d. Describe how injury occurred

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year 900PM Jean Α. Shorter 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Kehab & hurs der 1 Year | If Jonder 24 Hrs. hs Days Hours Min. Wicomico. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Months 579-38-2347 79 04/19/1930 Maryland Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 Civic Ave. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housewife domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown lillian Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Smullen/grandson 701 Maryland Ave., Cambridge MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7/23/09 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee Thornama and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or n spiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 7No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

**Physician** 

**Examiner** 

**Funeral** 

Director

1 and 2 should be filed within 72 hours after death with the Maryland

コピカ Shorter Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, IIs Medical Exp. if at must be notified at once.

/Medical

Director

Funeral

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Completed

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Examiner Be

burial-transit and attending physician for use as the buria Physician/Medical signed by the a d be detached f þ Completed page 2 should peen has certificate this certific al director, funeral c After 1

Records, P.O. Box 68760,

Division of Vital

Certification: To n 24 hours after death.

In Funeral Director: Aft bletely filled in by the fun Medical

1 Matural

2 Accident

4 Homicide

3 Suicide

5 Pending

JUL 23

investigation

determined

6 Could not be

npletely the the within 7 ٥

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1D. 200 32 Registrar's Signa 31. Date filed (Month

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year 425 M mrot mith 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional medical Wicomia ninsula (antar If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** ay, Year) Months Days Hours Min. Director Delaware Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinational by notified at 10d. Inside City Limits MD 1 Yes 2 No Director e 1 COMICO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. Funeral amina 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Follows: 1 Seyes 2 No If Yes, Give Year or Dates: Ajmy 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnesia. College (1-4or 5+) Grade OETVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 entain 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mardela Springs Md. 21837 1)omingo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-27-200 rematoryllc 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Hennie Smith
Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. A proximate Interval Between Onset and Death Immediate Cause (Find disease or condition resulting in death) Physician THEMSCLERATIC /Medical Due to (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has 24a. Was an autopsy performed? Yes 212 No Hospital or Attending Physician: The 24 hours Iter death. certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home Certification: To 1 Yes 2 🗆 No 2 ER/Outpatient 3 □ DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 🗆 No within 24 hours fer deal To the Funeral Director pletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Pate signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6/4 31. Date filed (Month, Day, edistrar's Signature State Year 2 4 2009 Registrar

1 - For State Registrar 1. Decedent's Name

Be Completed by Funeral Director

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**Physician** 

/Medical

**Examiner** 

**Funeral** Director

	Plea	ase Type or	Prin	t in B	lack Inc	delible	e Ink	Fnsı	ıre Δ	II Coni	es A	re Legi	ible		
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For State Registrar				,	•	rtificat					, 0	. No. 🤈 [	100	251,50	
1. Decedent's Nam	e (First, Midd	le, Last)								2. Date of	Death	6	1 4	3. Time of Death	
Char	les R	oy Tyler								July	25	<sup>Day</sup> 2009	Year	9:00 p. M	
4a. Facility Name (	If not institutio	n, give street and nu	ımber)			4b. City,	Town, or	Location	of Death			4c. County	of Death		
Mallar	d Bay	Care Cente	er			Ca	ambri	idge				Dor	chest	er	
5. Social Security N	lumber	6. Sex	7. Age	(In yrs. la	ast birthday)	If Under		If Under		8. Date of	Birth	(02 r)	9. Birth	place (State or Foreign	
219-60-0	393	1 M 2 □ F		57	Vrc							Mar	ryland		
Usual Residence of	f Decedent														
10a. State	10b. County			10c. City	, Town or Lo									10d. Inside City Limits	
MD	MD Dorchester					Can	nbrid	dge						1 ☐ Yes 2 ☑ No	
10e. Street and Nu	mber					10f. Zip	Code				100	. Citizen of	What Cou	ntry?	
5313 B		21613 USA													
1. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ₺ Divorced  12. Was Decedent Ever in Armed Forces?  1 ★ Yes 2 □ No If Yes, Give Year or Dates: 1971						13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Amer Black, White,  1 □ Yes 2X No Specify:  Specify: V							e, etc. white		
(Spec	15. Deceder	nt's Education est grade completed)		- I	16a. Deced	dent's Usua kind of wo	al Occupa	ation Juring mos	t of work	ina	16	b. Kind of B	usiness/In	dustry	
Elementary/Seco	<del></del>	College (	1-4or 5+	)	(Give kind of work done during most of working life. DO NOT use retired)  machine operator wire							cloth	loth mfg.		
17. Father's Name	(First, Middle,	Last)						18. Mothe	er's Nam	e (First, Mid	ldie, Ma	iden Surnar	ne)		
Henry	Hubert	Tyler						De	lla	Shorte	er				
19a. Informant's N	ame/Relations	ship (Type. Print)			19b. Mailin	g Address	(Street	and Numb	er or Rui	ral Route Nu	ımber, (	City or Town	, State, Zij	o Code)	
Michael	н. Ту	ler bro	othe	r	29536	Hem]	Lock	Lane	, Ea	ston,	MD	2160	1		
20a. Method of Dis	position			20b. PI	ace of Dispo	sition (Nar	ne of			Date		c. Location	- City or To	own, State	
1X Burial 2 l 4 □ Donation		3 □ Removal from Specify)	State		emetery, cren yland				7/3	0/09		Hurlo	ck, M	ID	
21. Signature of Fu	ineral Service	Licensee				. Name an				omas E mbrid		eral Ho	ome F 1613	P.A.	
23a. Part 1. Enter t	he disease, o	r complications that	caused t	he death	. Do not ent	er the mod	e of dyin	g, such as	cardiac	or respirator	ry arres	t,		Approximate Interval Between	
Immediate Cause disease or condition resulting in death)	(Final	a	a	consequ	80 A	elu	ete	ė _	H	cost	d	isee	20	Onset and Death	
Sequentially list conference if eny, leading to imcause. Enter Under Cause (Disease or	rlying	b	E	consequ	St	age	Re	rel	de	200	2l_				

**Physician** /Medical Examiner

	21. Signature of Furieral Service Licer	See	700 Locust St., Co	nomas runer ambridge M								
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. Do not one cause on each line.			2000	Approximate Interval Between Onset and Death						
dical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of de Month	livery Day Year									
ted by Pr	Part II. Other significant conditions of	contributing to death but not resulting in the	ne underlying cause given in Part I.		use contribute to	the cause of death?						
Complei				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of						
Be	25. Was case referred to medical examiner?	Hospital:	Othor	ath (Check only one)								
1: 10	1 ☐ Yes 2 🖾 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/Outpa	atient 3 DOA 4 Nursing I	Home 5 Residence		ecify)						
ation	1 Maturai 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inju	rry Work? M 1 □Yes 2 □ No	Zod. Describe now inj	ary occurred							
Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street a City or Town, Sta		ural Route Number,						
dical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	aysician: To the best of my knowledge, on the basis of examination and/on and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner a nd place, and due	s stated. e to the cause(s)						

Medical

State

30. Name and address of per

31. Date filed (Month, Day, Year)

JUL 29

29b. Signature and title of certifier

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Tyler Charles Calvin JULY 20 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Year If Under 24 Hrs. Peninsula Regional Medical Center Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Davs Min 1**▼** M 2□ F 218-16-8878 84 09/28/1924 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f show Ever incr must be notified at 1⊈Yes 2 No Director Wicomico Salisbury Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21801 USA 440 Monticello Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status 1 Never Married 2 Married d other than "natural", or i Maryland 21215-0036 1 □Yes 2 No Specify: If Yes, Give Army Year or Dates: Army Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other traumatic event, Ins. once. financial accounting certified public accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pina Sterling Fred Tyler 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 440 Monticello Ave., Salisbury, MD 21801 Joy F. Tyler/spouse Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Wicomico Memorial Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/27/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature, f Funeral Service Licenses <sup>22</sup> Name and Address of Facility at Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Compson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ear **Physician** morare disease or condition resulting in death) /Medical Due to (or as a cons nuence of): Examiner oan Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner be executed resulting in death) Last Due to (or as a consequence of): buria Box 68760, physician Physician/Medical that the death certificate the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No Ö 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? has certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1XYes 2 □ No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No death. 2 Accident To the Hospital or Attenowithin 24 hours after death To the Funeral Director: the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

SAlisbury Md.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kobin

July 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year WDERWOOT 4.30 A M REDERICIC 2009 29 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sanctuary at Holy Cross Montgomery Burtonsville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 1XM 2□ F Months Days Hours Min. 577-36-0899 80 July 9,1929 Wash.,DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10510 New Hampshire Avenue 20903 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DC Police Dept. Police Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eausaw Underwood Florence Conway 19a. Informant's Name/Relationship (Type. Print) wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10510 New Hampshire Avenue Silver Spring, Md. 20903

Date of Disposition (Name of Date 200 Audrey Robinson Underwood/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

Rock Creek Cemetery 8/5/09

NEUMONIA

"natural", or items 23a or s 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. Baltimore, Maryland 21215-0036 event, the Medical 7 is marked other it 27 Item 27 other t Pages 1 = 5 important: If any injury o

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

or items

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG

TASNEEM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AICHAMI,

4 ☐ Donation 5 ☐ Other (Specify)

21. Signiture of Funeral Service Licenses

death with the Maryland

**Physician** /Medical Examiner

> the burial-tran physician for use as attending signed by the a d be detached for should page 2 s has certificate director. this

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIO MYOPATHY 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital 1 Yes 3 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Natural 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line.

SARATION

Washington, DC 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: funeral After Director: filled in by the Hospitai within 24 hours To the Funeral

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) nn

SUITE 203

State Registrar

2835

Mi

32. Registrar's Signature

			State of Maryla  State of Maryla  Population	•	artment of H			iene <sub>eg. No.</sub> 201	19	25462
			Negistrar  1. Decedent's Name (First, Middle, Last)		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		2. Date of Deatl	h		3. Time of Death
	Physicia		Alice Elizabeth Vecchi	0			July	27 200	ear 19	4:30 a <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	1	4c. County of Death		
			Lorien Bel Air			Air			larfo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In )	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 24	Year) 9	Birthpla Countr	ce <i>(State or Foreign</i> y) nsylvania
	Director		214-12-8751 9	7 Yrs.			July 24	, 1912	Peni	nsylvania
	and w			City, Town or Lo	cation				100	d. Inside City Limits
	Mary -f sh	ţţ	Maryland Harford		Church	ville				1 □ Yes 2 💢 No
	r 28a	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wha	t Countr	y?
	th wit	la [	3012 Rolling Green Drive		210	28		U.:	S.A.	
	rdea	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black, \	America White, et	
36	s afte	by F	1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1∐Yes <b>X</b> XNo	Specify:		Specify:	Wh	ite
8	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, Ite Wedical Exambrations to colling.	edt	15. Decedent's Education	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busir		
212	in 72	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	luring most of work )	ring	Hair Sa	lon	
21.	d with giene er tha	mo.	Eleven Years		Hairdre				lle,	Maryland
p	e file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Nam			,	
Уa	Duld L Ment arked	P	Oscar Roy Evans					abeth Eb		
Mar	h and h and		19a. Informant's Name/Relationship (Type. Print) B. Audrey Buck (Daughter)		ng Address <i>(Street a</i> Turkey Po			-		
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should l Department of Health and Men Important: If item 27 Is marke any injury or other traumatic once.		, , , , , , , , , , , , , , , , , , , ,				·	20c. Location - Ci	<u> </u>	
ğ	Pages nent of int: If its iry or o		A Burial 2   Cremation 3   Hemovar from State	Bel	osition (Name of matory or other place Air		20/00	Dal Atm	Мам	uland
<u>=</u>	permit. Pages Department of Important: If it any injury or conce.		21. Signature of Funeral Service Licensee	lemorial	Gardens 2. Name and Addres	s of Facility		Bel Air,		
ä	Dep Per Suny Suny	7	Alphanes Malas RANSA	5	Lee A. Pa	tterson 8				Ŗ.A.
			23a. Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.	leath. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between
inde.	Physician	i N	Immediate Cause (Final disease or condition Dementia	a, End S	tage					Onset and Death
	/Medical		resulting in death)  Due to (or as a con	sequence of):						
	Examiner	_	Sequentially list conditions, b.							
	ted nsit	nine	If any, leading to immediate Due to (or as a con cause. Enter Underlying Cause (Disease or injury	sequence or):						
	execu n and al-trai	Examiner	that initiated events c Due to (or as a con	sequence of):						
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d.							
9	tificat ng phy as th	fedi								-
Box	leath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐		☐ Ectopic pregnancy	/		23d. Date		,
Е	e dea the at red fo	sici	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time		Other (specify)			Monti	1 1	Day Year
P. O.	w requires that the diben signed by the should be detached	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause give	en in Part I	23e. Did to	bacco use contrib	ute to the	e cause of death?
ds,	signe d be c	by	Hypertension, Diabetes Mell	_			1 □ Ye			ably 4 Unknown
20	v requ been shoult	Completed	Heart Failure, Hypothyroid,	Cardia	c Arrhyth	mia	24a. Was a	n 24h We	re auton	sy findings available
æ	Physician: The lav this certificate has al director, page 2.9	ldmo	near traite, hypothyrora,	, our ara	C / II I II Y CIII	iii u	autons	me∡d?   dea	ath?	sy findings available pletion of cause of
ā	an: T tificat or, pa		25. Was case referred to medical			26 Place of Dea	1 ☐ Yes th (Check only on		]Yes	2 LINo
>	ysicia is cer direct	o Be	examiner?	2 ER/Outpatie	nt 3 DOA Othe			ence 6 Other	(Specify	·)
0	ng Ph ter th	n:T	27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day, Yea	28b. Time o	of 28c. Injury Work			ow injury occurred		
<u></u>	endir eath. or: Ai	atic	2 Accident investigation		M 1 □¹	Yes 2□No				
Division of Vital Records,	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - / building, etc. (Sc	At home, farm, st pecify)	reet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	or Rural	Route Number,
	pital		29a. Certifier 1 Certifying Physician: To the best of my	knowledge dea	th occurred at the tir	ne date and place	and due to the	cause(s) and man	ner as st	ated
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p	edical	(Check only 2 Medical Examiner: On the basis of exal one) and manner stated.							
	To the within To the Comp	Me	29b. Signature and title of certifier	10	29c. License	e number	2	29d. Date signed (	Month, L	Day, Year)
			> Judgan	MS	D45	344		July 2	7	2009
	_		30. Name and address of person who completed cause of death							1000
	5		Suresh Dhanjani, M.D., 622 Sc 31. Date filed (Month, Day, Year) 32. Registrar's S		on Avenue	, Havre	de Grace	, Maryla	nd 2	10/8
2.4	Sta Registr		JUL 2 8 2009		backer					
			111 2.75 /UUJ / KANA	The Him						

DHMH 17 Rev 1/2001

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			Tor State Registrar	e of Marylan	•	artment of H rtificate of L		-	giene Reg. No 20	09	25463
	Physic	ian	1. Decedent's Name (First, Middle, Last)	n Whitmore				2. Date of De Month		Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give street and		e 	4h City Town or	Location of Death	7- 1	L7- 200 4c. County	19	1:15am M
1	Exami	ner	Crofton Convalesce		r	Crofton	Location of Death		Anne		le1
	Funeral Director		5. Social Security Number 002-16-6832 6. Sex 1 → M 2□	7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ay, Year) .8–1924	9. Birthp Coun	elace (State or Foreign etry) Maine
	land ow		Usual Residence of Decedent  10a. State  10b. County	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	e Mary ka-fsh lifted	ctor	Maryland Anne Arundel	. Ga	ambril]	Ls					1X Yes 2 No
	vith the	Dire	10e. Street and Number			10f. Zip Code	- ,		10g. Citizen of \	What Coun	try?
	eath v	Funeral Director	2211 Huntfield Ct.	Decedent Ever in U.	S 13	210		ocify Ves or No	USA 14 Bac	e - Americ	an Indian
9800	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be redited at	b	Arme 1 □ Never Married 2 □ Married 1 ☑ Yes	d Forces? es 2  No , Give or Dates:		if Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White, e געונה	etc.
15-0	"natu	letec	15. Decedent's Education (Specify only highest grade comple	'ed)	16a. Dece	dent's Usual Occupa	ation furing most of workin )	ng	16b. Kind of B	usiness/Ind	dustry
212	ywithir giene. r than	Completed	Elementary/Secondary (0-12) College	2 (1-4or 5+)	1	1yst	,			Depa	rtment
pu	be filectal Hygen of tall Hygen of the swent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name			,	
ryla	d Men marked matic	욘	Al Whitmore		T		Gladys				
Ma	nd 2 sl alth an 27 is r r trau		19a. Informant's Name/Relationship (Type. Print) Tim Whitmore			•	and Number or Rura 1 Ct. Gaml			,	Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natura any Injury or other traumatic event, In Medical once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crer	sition (Name of natory or other place c Cremato	e) D	ate	20c. Location - Glen Bu	City or To	wn, State
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee	M0054		2. Name and Addres	s of Facility Ro	obert E Rd Bowi	Maryla Evans e, Md.		ral Home
			23a. art 1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death on each line.	h. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory a	rrest,		Approximate Interval Between
d	Physician		Immediate Cause (Final disease or condition resulting in death)	chemic C	Cardion	yopathy					Onset and Death years
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	D ±	ner	Sequentially list conditions, b.	to (unes a euroseq							<b>J</b>
	icate be executed physician and the burial-transit	Examiner	that initiated events c.	bility to (or as a consequence)							years
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	tificate ng phy as the	ledical	a					-			
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	outcome of pregna ive birth 2□ Feta regnant at time of d Inknown	Ideath 3	Ectopic pregnancy Other (specify)	,		1	te of delive	ery Day Year
œ.	ires that the de signed by the a be detached to	by Ph	Part II. Other significant conditions contributing	to death but not resu	ulting in the ur	nderlying cause give	n in Part I.	23e. Did to	obacco use cont	ribute to th	e cause of death?
ords	w require s been sig should b	ted b	Diabetes Mellitu	S				101	res 2 No	3□ Prob	ably 4 ☐ Unknown
of Vital Records,		Completed		<u> </u>				24a. Was autop perfo 1 □ Yes	rmed2	Were autop prior to cor death? 1 ∐Yes	psy findings available inpletion of cause of
Vita	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?			A A T POA Othe	26. Place of Death	•			
	ding Phys h. After this funeral di	n: To	27. Magner of Death 28a. D	☐ Inpatient 2 ☐ ate of Injury	28b. Time of	28c. Injury	at Nursing Hon		dence 6 □Oth now injury occurr		<u>()</u>
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. P	Month, Day, Year) lace of Injury - At houlding, etc. (Specification)	Injury ome, farm, stre		res 2□No	28f. Location (8 City or Tov		er or Rura	l Route Number,
	he Hospit in 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To Certifying Ph	the best of my kno ne basis of examina nanner stated.	wledge, death	n occurred at the time vestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)
	To the Complex	M	29b. Signature and title of certifier	WN	MM	29c. License	number ) 2 0 /	08	29d. Date signe	d (Month, 1	Day, Year)
C	411		30. Name and address of person who completed of								
5	Sta	te	Rakesh Arora 1430( 31. Date filed (Month, Day, Year) 3				222, Bow	ie, MI	20715	5	
	Registr		JUL 2 U 2009	Genera	p. 4	race					

			1 - For Registrar	State of M	arylan		artment rtificate			and M	-	giene Reg. No	000	Q :	25464
			Decedent's Name (First, Middle, Last)				1,,,,,,,,,,			-	2. Date of De	ath	Bloom New Sale	3.	Time of Death
	Physici		PHYLLIS	MARIE		WILLI	AMS				Month JULY	22 /	y Yea 2009	r 1	1:49A M
mga Zo	/Medid Examir		4a. Facility Name (If not institution, give s	street and number	)		4b. City, T	Town, or	Location of	of Death	0.0111		. County of De	ath	
			FREDERICK MEM	ORIAL HO	SPITA	L	F	REDI	ERICK				FREDER	ICK	
	Funeral		Social Security Number     6. Sex	7. A	ge (In yrs. i	last birthday)	If Under	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Year)	9. E	Sirthplace Country)	(State or Foreign
4	Director		213-66-2709	IM ZLXF	55	Yrs.					7/11/5	54	N	1D	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. lr	nside City Limits
	Maryl f sho	ē	MD Frederick	:	Mt.	Airy								13	XiYes 2 □ No
	r 28a	Director	10e. Street and Number		1		10f. Zip	Code				10g. Cit	tizen of What	Country?	
	3a o		107 West Manor Ct.				217	771				U.S	5.A.		
	death	Funeral		12. Was Decedent Armed Forces		S. 13.	Was Decede	ent of H	ispanic Ori	igin? (Sp	ecify Yes or No	>-	14. Race - Ar Black, Wh		dian,
9	or ite		1 ☐ Never Married 2X Married	1 ☐Yes 2 🔀			1		Specify:		rtioari, oto.)		0		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Wedical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:									1	Black	
15-	"nat	Completed	15. Decedent's Educ (Specify only highest grade	cation co <i>mpleted)</i>		16a. Dece (Give	dent's Usual kind of work DO NOT use	l Occup k done d	ation <i>during m</i> os	t of work	ng	16b. K	ind of Busines	ss/Industry	1
12	withii iene. <b>than</b>	E C	Elementary/Secondary (0-12)	College (1-4or	5+)		Proce					Moi	rtgage		
0	i filed I Hyg other	Be C	17. Father's Name (First, Middle, Last)	-					18. Mothe	er's Name	(First, Middle				
a	ald be denta rked ric ev	To B	Lawrence Howard						Rowe	nda	Chambei	CS			
Maryland	and N	-	19a. Informant's Name/Relationship (Type	oe. Print)		19b. Maili	ng Address	(Street	and Numbe	er or Run	al Route Numb	er, City o	or Town, State	, Zip Code	e)
Σ	and 2 salth n 27 i		Charlie Thomas Wil	liams		107 7	Vest M	lano:	r Ct,	Mt.	Airy,	MD 2	21771		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Walfort Eventine must be notified at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. P	lace of Dispo employ, crei	sition (Nam natory or oti	ne of ther plac	e)	[	Date	20c. Lo	ocation - City	or Town, S	State
Ē	Pag tment tant: jury o		4 □ Donation 5 □ Other (Specify)	12	All		s Ceme	-		7/30			rmantov		
Ball	ermit Depar npor nny In		21. Signature Funeral Service L	0//	. A).						owden I			•	
	□ □ = # O		suge 1	Just							t, Rock		Le, MD		
1		S	23a. Part 1. Enter the disease, or complishock, or heart failule. List only of	e cause on each i	a the deatr ine.	not en	er the mode	e ot ayın	g, such as	cardiac	or respiratory a	irrest,		Inte	roximate rval Between set and Death
and and	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cand		ARE	551								
-	Examiner			Due to (or as	a consequ	uence of):									
		ē	Sequentially list conditions, if any, leading to immediate	 Due to (or as	a consequ	uence of):								-	
	outed id ansit	Examiner	Cause. Enter University Cause (Disease or injury that initiated events												
o o	e exerian ar		resulting in death) Last	Due to (or as	a consequ	uence of):									
8760,	ficate be executed physician and s the burial-transit	dical													
9	ertific ing p e as t	Med	IF FEMALE:									-			
Box	eath certific attending p for use as	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 Live birth	2 Feta	death 3	Ectopic pr		y				23d. Date of o	delivery Day	Year
o -	at the de by the a stached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of d	leath 5	Other (sp	ec <i>ify)</i>						,	
σ.	requires that the death certifi been signed by the attending I nould be detached for use as	문	Part II. Other significant conditions con	tributing to death I	out not resu	ulting in the u	nderlying ca	use give	en in Part I		23e. Did	tobacco	use contribute	to the car	use of death?
Vital Records,	uires n sigr ld be	d by	Chronic Ob.	struck	ve	Pul	man	any	dix	rac	0 1 🗆	Yes 2	<b>□</b> ₩0 3□	Probably	4 🗌 Unknown
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a	an: rtfica tor, p	BeC	25. Was case referred to medical						26. Place	of Deat	1 ☐ Yes	2 Ando	) 1 LIY	es 2□	INO .
>	nysici iis ce direc		examiner?	ospital: 1 ☐ Inpat	ent 2	ER/Outpatie	nt 3 🗆 DO	A Oth	or:		me 5 Res		6 ☐ Other (S	pecify)	
0	ding Physician: The lav h. After this cert ficate has funeral director, page 2	Ę.	27. Manner of Death 1. ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury a <i>y, Y</i> ea <i>r)</i>	28b. Time o Injury	f 28	8c. Injur Work	y at		28d. Describe	how inju	ry occurred		
<u>S</u>	Attendi death. ctor: A y the fu	cati	2 Accident investigation				М		Yes 2	No					
Division of	il or Attend after death Director: / d in by the f	Certification: To	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i>	ome, farm, str y)	eet, factory,	office			28f. Location ( City or To	Street ar wn, State	nd Number or e)	Rural Rou	ute Number,
	pital		29a Cartifiar 12 Cartifying Phys	rician: To the best	of my kno	wledge deat	h conurred	at the tir	no doto o	nd place	and due to the		a) and manna	on stated	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 ⁴	Medical	29a. Certifier Certifying Physics (Check only one) 2 Medical Examination	ner: On the basis and manner s	of examina	tion and/or in	vestigation,	in my o	pinion, dea	ath occur	red at the time	, date an	d place, and c	as stated lue to the	cause(s)
	vithi To the	ž	29b. Signature and title of certifier						e number				ate signed (Mo	-	
	6		Mes 1	ND			_ 1	>60	041	7		フー	22-	09	
			30. Name and address of person who co	mpleted cause of	death (Item	1 23a) (Type,	Print)			V					21702
			1 temen shah 31. Date filed (Month, Day, Year)	65 C	rar's Signa	mas	Joh	ms	230	DY	FYY	der	Trec	MD	21/07
	Sta	1(2)	Date med (mornin, Day, rour)	J. Hogist	orgina										

State Registrar

parked

			For State	State of Marylar		artment of F <i>rtificate of I</i>				1000	05165
			Registrar  1. Decedent's Name (First, Middle, La	st)		Timeate of i	Deam	2. Date of De	Reg. No.	CUUS	3. Time of Death
	Physici /Medic		CORRIE BLAN	CHE WILLIAM	S			July :		200 <sup>9</sup>	5:00 A M
	Examin	er	4a. Facility Name (If not institution, giv		- 1		r Location of Death			ounty of Death ontgom	
	Funeral Director		Montgomery Ger 5. Social Security Number 218-24-3085			Olney If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Date of 125 /	rth ay, Year)		nplace (State or Foreign intry)
	ס		Usual Residence of Decedent			1		0/43/.			
	arylan show dat	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits 1 ☐Yes 2X No
	he Ma 28a-f otifie	Director	MD Montgon  10e. Street and Number	nery Si	lver_	Spring 10f. Zip Code			10a Citize	tizen of What Country?	
	with t	ğ	15700 Good Hop	ne Rđ		20905	5			6.A.	,
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H		ecify Yes or No		. Race - Amer	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, its in edical Exminer must be notified at once.	þ	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		1 ☐ Yes 2 XNo	Specify:	rican, etc.)		Black, White, etc.  Specify: Black	
2-0	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retired	pation during most of work	ing	16b. Kind	of Business/Ir	ndustry
121	within ene. than	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+)		maker	a)		Ho	ome	
0 0	filed Hygi Sther ent, II	CC	17. Father's Name (First, Middle, Last	<del></del> )	Home	indice I	18. Mother's Nam	e (First, Middle	1		
<u>a</u>	Aental Aental rked c	To Be	Oliver Barks				Alice	Johns	on		
Maryland	shou and N is mai		19a. Informant's Name/Relationship	(Type. Print)		ing Address (Street					
Σ.	and 2 lealth m 27 i		Sylvia Crowder			9 Foster					
Baltimore,	ages 1 nt of H : If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	1 Hellioval Holli State		osition (Name of matory or other plate	1	Date		ation - City or T	
≣	nit. Pa artmel ortant Injury		4 □ Donation 5 □ Other (Special 21. Signature & Funeral Service Une	(y)   GA	orge	Washingt	ton : 7/2	25/09		lphi,	MD ome, P.A.
Ba	Departing Department Important In any Irr		Jenay 1	Summer							, MD 2085
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	prications that caused the dear		iter the mode of dyin					Approximate Interval Between
in,	Physician		Immediate Cause (Final disease or condition	- PANCRE		CANCE	R				Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	1100					
	Lxammer	<u>.</u>	Sequentially list conditions,	b. LIVER		4STASIS	>				
	uted J Insit	Examiner	duly, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	FAILUR							
oʻ	exection and and rial-tra	Еха	resulting in death) Last	Due to (or as a consec	THRIVE						
68760,	ate be hysicia he bul	edical		<b>d</b>							
39 ×	ertifica ling pl e as ti	Med	IF FEMALE:	00 15							
O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death.  Yo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	<b>су</b>		23	3d. Date of deli Month	ivery Day Year		
σ.	ires that the de signed by the a I be detached I		Part II. Other significant conditions	contributing to death but not re-	sulting in the I	underlying cause giv	en in Part I.	23e. Did	tobacco use	e contribute to	the cause of death?
rds	en sig	ed by						1 🗆	Yes 2	No 3□ Pro	obably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director. After this certificate has been s completely filled in by the funeral director, page 2 should	Completed						24a. Was auto perf 1 ∐Yes		prior to c death?	topsy findings available completion of cause of
<u>ita</u>	sian: ertifice ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Dea				
<u>&gt;</u>	hysic this co		1 ☐ Yes a ☑ No	Hospital: Inpatient 2	<del> </del>		4 🗆 Nursing n				cify)
n C	ling P I. After i funera	ion:	27. Manner of Death  1  Natural 5  Pending	28a. Date of Injury (Month, Day, Year)	28b. Time Injury	Wor	ryat rk? ]Yes 2 ∐ No	28d. Describe	how injury	occurred	
isic	Attence death	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	l nome, farm, s		ites 2 🗆 140			Number or Ru	ıral Route Number,
<u>&gt;</u>	al or / s after il Dire	Serti	4 ☐ Homicide	building, etc. (Spec	ify)			City or To	own, State)		
	ne Hospit 24 hour e Funera letely fille	Medical C		hysician: To the best of my kn miner: On the basis of examin and manner stated.							
	vithir comp	Me	29b. Signature and title of certifier		se number			signed (Month			
	5		Ju / Jun			DOC	59414	/	5	JLY 2	1,2009
			30. Name and address of person who			, Print)				2.0	
			Vladimir Rakhm 31. Date filed (Month, Day, Year)				Dr, 01	ney MI	208	32	
	Sta Registi		JUL 27 20	32 Registrar's Sign	A. 100	who.					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Cheryl Lynn Yarema 2009 23 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WICOMICO Peninsula Regional Medical Cente 8. Date of Birth (Month, Day, Year) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Months Days Hours Min. 62 221-34-3671 Yrs. Jan 17,1947 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7464 Esham Road 21849 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 1 Married Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietary Aide State Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis Jackson Adkins Margaret Ann Truitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael R Yarema, Sr/spouse 7464 Esham Road, Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Mem Gdns. | 07/28/2009 Hebron, MD 21. Signature of Funetal Service Licensee 22. Name and Address of Facilit Short Funeral Home 3 E. Grove St, Delmar, DE 19940 23a. Part 1. Enter the disease, or complice shock, or near trailure. List only one disease, or complications that Approximate Interval Between Onset and Death caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) 541 Atheroscleretic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 PNo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

1 ☐Yes 2 ☐ No

024986

B101 Sali/b-rg

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24/09

Physician: The law requires that the death certificate be executed burial-trar and Box 68760, physician the attending use for signed by the a o ₫. Division of Vital Records, page this certificate director

Examiner Physician/Medical þ Completed Be 20 Medical Certification:

**Physician** 

/Medical

Examiner

10a, State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, i'm Medical Examinat must be notified.

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Event

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

death with

Hospital or Attending nours after death.

neral Director: Aft

y filled in by the fun To the Hospital o within 24 hours af To the Funeral D completely

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Natural

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

5 ☐ Pending

investigation

determined

Reillx

6 ☐ Could not be

32. Registrar's Signature

560

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MY

Riverside

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0.55 am ormar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8595 Horseshoe Road Ellicott City Howard Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Social Security Number **Funeral** Year) Hours Months Davs 1₽M 2□ F 006-34-3849 72 19 Jul. Maine Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examinat riust be multimed at 1 ☐ Yes 2 【No Director MD Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8595 Horseshoe Road 21043 United States r death v Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2XXNo Specify. If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed 4 🕅 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) United States College (1-4or 5+) and Mental Hygiene. Sargeant Major 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hi Important: If item 27 is marked oth any Injury or other traumatic event Be Albert Anderson Marion Rokes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4249 Rinehart Road, Westminster, MD 21158 <u>Tina Levering - Daughter</u> 20b. Place of Disposition (Name of 20a. Method of Disposition cometery crematory or other place) West Arundel 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-8:-2009 | Odenton, MD Crematory 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signal re June Service Licensee 2719 Hammonds Fry Rd., Lansdowne, MD 21227 an 440 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and execu burial-tra Due to (or as a consequence of) Box 68760. attending physician certificate be Physician/Medical the as IF FEMALE ase yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Š signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

DHMH 17 Rev 1/2001

completely

Registrar

(Check only one)

29b. Signature and title

31. Date filed (Month, Day

30. Name and address of person wh

Year

**ORIGINAL** 

and manner stated

completed cause of death (Item 23a) (Type, Print)

	Plea	se Type or	Print in E	Black I	ndelible	lnk.	Ensu	ıre Al	I Copies	Are	Legi	ible.	
For State Registrar		State	of Marylan		oartment e <i>rtificate</i>			and M	-	gien Reg. N	en e	100	2546
1. Decedent's Name	e (First, Middle	e, Last)							2. Date of Dea		ay	Year	3. Time of Death
Jam	es Fl	emon Boy	/d						Augus			009	10:05 A <sup>M</sup>
4a. Facility Name (// Upper Cl		n, give street and nu ke Medica	,	r	4b. City, To	_	Location Air	of Death		4		y of Death	
5. Social Security N	umber	6. Sex	7. Age (In yrs.	last birthda			If Under		8. Date of Bir (Month, Da	th You	r)	9. Birtl	hplace (State or Foreign untry)
212-30-0	430	1 <b>₩</b> M 2□ F	82	Yrs.	Months   I	Days	Hours	Min.	May 23				ginia
Usual Residence of	Decedent												
10a. State	10b. County		10c. Cit	y, Town or	Location								10d. Inside City Limits
MD	На	rford		Abir	igdon								1 □Yes 2 No
10e. Street and Nur	mber				10f. Zip C	Code	-			10g. C	itizen of	What Co	untry?
123 Wa	lden Ro	ad Apt. H	I		21	1009					USA		
11. Marital Status 1 ☐ Never Marri 3 ☑ Widowed		Armed F	2 □ No ive	If Yes, specify Cuban, Mexican, Puèrto Rican, etc.)						ck, White	rican Indian, e, etc.		
/Fac	15. Deceden			16a. De	cedent's Usual	Occupa	ation	nt of work	ina	16b.	Kind of B	Business/I	Industry
Elementary/Seco		college (		life	intaine	retired)	)	n or work	n ig	Fo	ster	's l	Hardware
17. Father's Name		•			_				e (First, Middle, Jones	Maide	n Surnai	me)	
19a. Informant's Na	ame/Relations	hip (Type. Print)		19b. Ma	iling Address (	Street a	and Numb	er or Rur	al Route Numb	er, City	or Town	, State, Z	Zip Code)
Charles 1	Boyd-sc	n		123	Walden	Roa	d Ap	t. H	-Abingd	on,l	Mary	land	21009
20a. Method of Dis 1 ★Burial 2   4 ☐ Donation	Cremation	3 □ Removal from pecify)	State Jess	emetery, c cop Uni	position (Name rematory or other ted Meth	er place			3, 2009			,	Town, State Le,Maryland
21. Signature of Fu	1	Licensee	rold		22. Name and			,	el and	Cre	natio	gn Şe	ęŗyjces

**Physician** /Medical

Examiner Examiner

Physician/Medical

2

Completed

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Medical Certification: To

Director

by Funeral

Completed

Be

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, I'm Medical Exemine in nat be notified at

and signed by the attending physician the use as t detached for been :

certificate be To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral

TO DOMACION O CONTO (OP	Church (Emercy	
21. Signature of Funeral Service L	icensee 22. Name and Address of Facility	
Cardine L	Evans Funeral Chapel and Crematic 16924 York Road Monkton, Maryland	an Serv
23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	A In
Immediate Cause (Final disease or condition resulting in death)	- CARDIAC ARRYTHMIA	
	Due to (or as a consequence of):  b. CORONARY ARTERY DISEASE	
Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	
that initiated events resulting in death) Last	c Due to (or as a consequence of):	
	d	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live hirth 2 Fetal death 3 Fetanic pregnancy	ate of delivery lonth De

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 3 Probably 4 ☐ Unknown ACUYE 1 ☐ Yes 2 ☐ No CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed DISEASE CEREBRO VASCULAR 1 □Yes 2 🗹 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

TTENDING PITYSICIAN

29c. License number DO21207 29d. Date signed (Month, Day, Year) AUGUST 9TH 2009

Approximate Interval Between Onset and Death

5 MINUTES

30 YEARS

Year

Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A FRANZ C. VELLA-CAMILLER! FRANZ C.

M.D. 5 MIDCREST CT., BALTIMORE, IND 21286

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 1 1 2009



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6, 2009 Olga A. Bell 10:10 AM August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day) Days Hours Min. 1 □ M 2 🖫 F 67 Maryland 218-40-2612 July 2, 1942 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Baltimore Parkville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 U.SA. 3023 Lavender Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo White Specify: 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angeline Melnick Frank Nechay 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4538 E. Joppa Road, Perry Hall, MD 21128 Lisa Enders/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/11/09 Roseadle, Maryland Cemetery
22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
Parkville, MD, 21234 21. Signature of Funeral Service Licensee 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line.

Immediate Cause Virial disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause on each line. 8800 Harford Rd., Parkville, MD. 21234 Approximate Interval Between Onset and Death spually dempensation disease or condition resulting in death) as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ie to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 3 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Beath 28c. Injury at Work? 28d. Describe how injury occurred ↑ Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 Suicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

**Physician** /Medical Examiner and burial-trar attending physician the as use for signed by the a d be detached for certificate this certific al director, funeral of Hospital or Attending Pl 24 hours after death. Funeral Director: After ti After 1 the filled in by within 24 hours a To the Funeral D соmpletely

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certification: To

Medical

**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Evanties are must be netified at

Maryland 21215-0036

Baltimore,

Pages 1

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month) Day, Year)

30. Name and address of pe

4 Homicide

(Check only one)

29b. Signature a

29a, Certifier

ordeath (Item 23a) (Type, Print) Asive Suile 201 Towson MD2/204. 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

535913

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 20b, perffl, G894,8 / 11/9, WI Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- Stateamend items 9.17 per inf g894 2-14-10 ate of Death Reg. No. 🧶 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 44 Year 200 Day. Month **Physician** 3:50PM tugust Willie James Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Season's Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1**X** M 2□ F 79 19 07 30 Director SC. <u> 249-46-8110</u> Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 ☐ No Director MD NA Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a 21215 U.S.A. 5341 Gist Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 72 hours after 1 Tes 2 Till If Yes, Give Year or Dates: 2 **N**O 1 Never Married Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🙀 No Specify: Black 9 Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Browns's Contractors Self Employed 3rd Grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Bell-Jeff Brown Louise Gray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s. Department of Health ar Important: If item 27 is any injury or other trau 5341 Gist Ave, Baltimore, Md 21215 Cleo Brown-Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4709 1409 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, Md King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa AFuneral Service Licensee 22 Name and Address of Facility March F/H West may 21215 4300 Wabash Ave, Baltimore, 23a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shuck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mme ate Cause (Final disease or condition resulting in death) Physician Non Small Coll Line /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician þe Physician/Medical The law requires that the death certificate use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🔲 Ectopic pregnancy for in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. the detached 1 ☐ Yes 2 ☐ No d be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other Specify NS 1705 PICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( ၉ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural
2 Accident To the Hospital or within 24 hours after death.

To the Funeral Director: Aft 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

**bb16** 

erson who completed cause of death (Item 23a) (Type, Print) exton

32. Registrar's Signatu

29c. License number

29d. Date signed (Month, Day, Year)

Smith Are Svite 203 Baltimore MD

		•	For State Registrar		aryianu	•	tificate of	Death		Reg. No	000	9 254	7
	Physici	an	1. Decedent's Name (First, Middle, Boris Bernard	Bushwick					2. Date o Month Aug		, 2009 <sup>°</sup>	3. Time of Dea 5:50 A	
	/Medid Examir		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of Deat			. County of De		
_	LXaiiiii	iei	Casey House				Rockville			Mc	Montgomery		
	Funeral Director		5. Social Security Number 6 071–18–9662 Usual Residence of Decedent	. Sex 1 M 2 □ F	e (In yrs. la. 86		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date o (Month Feb	Birth , Day, Year) 25, 19	9. B	Birthplace (State or Fo Country) W York	reign
	land ow		10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City L	
	Mary a-f sh	ţ	FL Broward	3	Cocc	onut C	reek					1 🗚 es 2[	□No
	or 28%	jrec	10e. Street and Number			<i></i>	10f. Zip Code			10g. Ci	tizen of What	Country?	
	23a c	ra [	2736 Calliandra	Terrace			33063			USA			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amportant: If Item 27 is marked other than "vatural", or Items 23a or 28a-f show amportant: If Item 27 is marked other traumatic event, the Medical Evantral must be notified at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:		48	Vas Decedent of H fYes, specify Cub □Yes 2X No	dispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes o to Rican, etc.	r No-	14. Race - Ar Black, Wh Specify: W		
5-0	72 hc 'natur	etec	15. Decedent's (Specify only highest	Education grade completed)	I	(Give	lent's Usual Occup kind of work done	during most of wor	rking	16b. K	(ind of Busines	ss/Industry	
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)		OO NOT use retire	d)		Dor	ntistry	,	
d 2	filed v Hygie other i		17. Father's Name (First, Middle, La			Denti	<u> </u>	18. Mother's Nar	me (First, Mic				
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Manatic event, the Manatic event, the Manatic event, the Manatic event.	To Be	Nathan Bushwick	,				Anna Rub					
ary	shoul and M s mar umat	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street	and Number or Ri	ural Route N	umber, City	or Town, State	e, Zip Code)	
	and 2 salth a r 27 is		Anita Bushwick/v	vife		2736	Calliand	ra Terra	ce Coc	onut (	Creek,	FL 33063	
Baltimore,	Pages 1 anent of He ant: If Item		20a. Method of Disposition  1 ☐ Burial 2 🏿 Cremation 3  4 ☐ Donation 5 ☐ Other (Spe				sition (Name of natory or other plan rney Cre		Date 08/10/0	_	ocation - City odbine,	or Town, State	
Balt	permit. Pages of Department of I important: If Ite any injury or of once.		21. Signature of Funeral Service Li	to att	MO12			"Cremation Heckrott					029
	Physician /Medical Examiner		Approximation for the first and the first an										
68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			_						
O. Box	the death certific y the attending p iched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	] Ectopic pregnand ] Other <i>(specify)</i> _	су			23d. Date of Month	delivery Day Ye a	ır
Records, P.	w requires that the do been signed by the should be detached	by	Part II. Other significant condition Atrial Fibrillat	s contributing to death b	out not result	ting in the ur	nderlying cause giv	ven in Part I.				e to the cause of deal	
000	s bee	Completed	Myocardial Infa	ction						Was an		autopsy findings ava	
æ	The law ate has bage 2 s	mo	-					•	1 1	autopsy performed? 'es 2 <b>∑√</b> Ne	death	to completion of caus 1? ′es 2 □ No	e or
of Vital	yslclan: The la	BeC	25. Was case referred to medical examiner?					26. Place of De			-		
₹	> 0 0		1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 🗆 E	R/Outpatien	it 3 □ DOA Oth	ner: 4 🗆 Nursing I	Home 5	Residence	6 XOther (S	Specify)hospice	e
n o		on:	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay, Year)	28b. Time of Injury	Wo	rk?	28d. Desc	ribe how inju	iry occurred		
Division	of after death.  Director: After din by the fune	Certification: To	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 28e. Place of In	jury - At hon tc. (Specify)	ne, farm, stre	M 1 C	]Yes 2□No		on (Street a r Town, Stat		Rural Route Number	r,
XI	Hospita 4 hours Funeral tely fille	Medical Co		Physician: To the best xaminer: On the basis and manner st	of examinati								
) '	To the within 2 To the comple	Me	29b. Signature and title of certifier  J. KOLLEL	chou:	MD		29c. Licens	se number 63748	>		ate signed (Mo	onth, Day, Year) 2009	
	Ü		30. Name and address of person w	ho completed cause of	death (Item :	23a) (Type,	Print)			1			
		y 10	Jocelyne Kouatch				er Mill	Rd. Rocky	ville,	MD 20	0855		
1	Sta		31. Date filed ( <i>Month</i> , <i>Day</i> , <i>Year</i> )  AUG 11 206	32. Regist									
DH	Registi		VAG 11 500	Beneda	A.	gark							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2009 Year Physician Aŭgust 6, Ralph Edward Blackwell 2:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 110 Minebank Lane Lansdowne If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Dec. 1, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Mary land 1 ▼ M 2 □ F 214-40-9567 65 1943 Dec. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location show er than "natural", or items 23a or 28a-f show 1 □Yes 2 No Director MD Baltimore Lansdowne 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 United States 110 Minebank Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2X No altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Ins. Ma. Once. Elementary/Secondary (0-12) College (1-4or 5+) Branch Manager Industrial Gases 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Culmer Bently Blackwell Lorriane F. Corbett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Linda Ann Blackwell - Wife 110 Minebank Lane, Lansdowne, MD 21227 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burjal 2 Cremation 3 Removal from State Loudon Park Cemetery 8-10-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Service Licer 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onsat and Death 23a. Part Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner l or Attending Physician: The law requires that the ceath certificate be executed after death. attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the aid be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l lirector, page 2 s autopsy perform 1 ∐ Yes 1 ☐ Yes 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home Fesidence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a, Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifie

cause of death (Item 23a) (Type, Print)

D18587

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Batimose funder 1 Year | If Under 24 Hrs. MMC n/a 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, 0/25/1931 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Months Days 1 □ M 2 🖵 F 212-28-0836 77 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21122 105 Dupont Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2√□No Specify. Specify: White 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' College (1-4or 5+) Elementary/Secondary (0-12) King Products Supervisor 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Violetta Sheldon Howard Weisman ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau
once. Bernard H. Bente, Jr. 8213 Wapati Ct. Pasadena, Maryland 21122 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) August 10, 2009 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. WNACO 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine P.O. Box 68760, 💢 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy nerforme 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Injury at Work? 5 Pending investigation 1 MNatural 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

SGREENE

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

ADA OFFULUM
31. Date filed (Month, Day, Year)

AUGUST 8, 2009

NI3W46, BATTIMBRE, MD 21201

# Baltimore, Maryland 21215-0036 Division or Vital Records, P.O. Box 68760, み

		Pleas	e Type or										ble.		
		For _ State	State	of Marylar		epartmeı C <i>ertifica</i>			and M						
		State Registrar  1. Decedent's Name (First, Middle,	Last)		•	Certifica	le oi L	Jean		2. Date of De	Reg. No.	20	09	3. Time of C	Death
Physicia		William Joel	-	on.						Month	Day		Year 2009	3:30	ΔM
/Medic Examin		4a. Facility Name (If not institution,				4b. City	, Town, or	Location of	of Death	Augus		7.1	of Death	_3.30	
-Admin	,As	178 Park Road					asade					Ar	ne Ar	unde1	
Funeral			3. Sex 14 M 2 □ F	7. Age (In yrs.		nday) If Under	Pr 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da	ay, Year)		Coun		_
Director		038-14-2331 Usual Residence of Decedent		82		13.				Dec. 1	5,192	26	Rhoc	le Isla	nd
yland sow		10a. State 10b. County		10c. Ci	ty, Town	or Location							10	d. Inside City	77
a-fsh	ctor	Maryland Anne	Arunde1	Pas	aden	ıa								1 □Yes	2 <b></b> XNo
hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Director	10e. Street and Number					ip Code				10g. Citi		What Coun	try?	
s 23a	Funeral	178 Park Road	10 Mac Da	cedent Ever in U	1.0		21122		igin? (Cno	ecify Yes or No			S.A.	an Indian	
ter de item	Fune	11. Marital Status 1 ☐ Never Married 2☐XMarrie	Armed F	orces? 2 □ No	1.5.	If Yes, sp	ecify Cuba	in, Mexical	n, Puerto	Rican, etc.)	_		ck, White,		
urs af al'; or Exam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	iive		1 ☐ Yes	2 ANo	Specify:				Specif		nite	
72 ho natur lical I	Completed	15. Decedent's (Specify only highest	Education grade completed	)		Decedent's Us (Give kind of w	ork done o	during mos	st of worki	ing	16b. Ki	ind of B	Business/Ind	lustry	
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filed v Hygie ther t		12 17. Father's Name ( <i>First, Middle, L</i>	ast)			Writ	er	18. Mothe	er's Name	(First, Middle			paper me)		
ld be lental ked o	To Be	William			Bur	ton		Milo	dred				(	Gilbert	
should be and N sumal		19a. Informant's Name/Relationshi	p (Type. Print)		19b.	Mailing Addres	ss (Street	and Numb	er or Rura	al Route Numb	er, City o	r Town	, State, Zip	Code)	
and 2 ealth r 27 I		Lois E. Burton (	Wife)			78 Park		l Pașa			_				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time Z7 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from		Place of cemeter	Disposition (Na y, crematory or	ame of other plac	- 1		Date			- City or To		
it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Sp 21. Signature of Fureral Service L		Ba	yvie	22. Name			08/11	./09	Ba1	timo	ore, N	Marylan	ıd
perm Depa Impo any I		21. Signature of Pullerar Service L	Cerisee			McCu1	ly-Po	lynia	k Fu	ineral Pasade	Home	P.	.A.	21122	
-4		23a. Part1 Enter the disease, or o	complications that	caused the dea	th. Don	ot enter the mo	ode of dyin	ig, such as	cardiac o	or respiratory a	arrest,	Mar.	yranu	Approximate Interval Betw	reen
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/Medical		resulting in death)	Due to	o (or as a conse	quence o		11101	0	/ +	1010		9.	/		
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The cate h	Com	Diabetes	Mellin	tus						perf 1□ Yes	formed? 2 No		death? 1 ☐ Yes	2) No	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Physician: To ti Examiner: On the and ma												)
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F > F 0		Hen.	wh.	Jel !	N	D	DO	064	117	-8	AL	190	ust 1	0,20	09
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		Decedent's Name (First, Middle, Last)				. Date of Death	CU 11 3	3. Time of Death	
Physic /Medi		Lula	Bulko		,	August_	9, 2009	3:30 A M	
Exami		4a. Facility Name (If not institution, give street and I	number)		Location of Death		4c. County of Death  Baltimo	n 0	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year		Date of Birth	Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)		
Director		223-26-3204 1□M 2ÅF	92 Yrs.	Months Days	Hours Min.	December 14	, 1916 Ken	tucky	
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vith the	Director	10e. Street and Number		10f. Zip Code	, , , ,	10g.	Citizen of What Cour	itry?	
leath v	Funeral	1904 Harrison Road  11. Marital Status 12. Was De	ecedent Ever in U.S. 13. V		'222 ispanic Origin? (Spec an, Mexican, Puerto Ri	ify Yes or No-	14. Race - Americ	an Indian,	
after o		Armed	s 2 <b>]</b> ₹ No	fYes, specify Cuba I∐Yes 2 <b>X</b> No	an, Mexican, Puerto Ri Specify:	can, etc.)	Black, White,		
hours hours	ed by	3 A Widowed 4 □ Divorced Year or	Dates:	lent's Usual Occup		166	Specify: Whi		
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2 should and Mer is marker	ဥ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street	and Number or Rural		ity or Town, State, Zip	Code)	
and 2 sealth ar n 27 is		Ronald Grissinger			Road, Duna			222	
paritimities, Mari yiallia 414.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandra I was be notified at any Injury or other traumatic event, the Medical Evandra I was be notified at any once.		20a. Method of Disposition  1/2 Burial 2 Cremation 3 Removal from	20b. Place of Dispos cemetery, crem			st 12,	. Location - City or To		
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions contributing to	death but not resulting in the ur	nderlyi <b>n</b> g cause giv	en in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?	
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	cal C	29a. Certifier  (Check only  2 Medical Examiner: On the	the best of my knowledge, death						
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		30. Name and address of person who completed ca	use of death (Item 23a) (Type,	Print)	( 11/		01/0/0	/	
10		A. Sanai, M.D. 6730 H	Colabird Avenue	, Dundalk	c, Maryland	21222			
St Regist	ate rar	ALIC 1 1 0000	Colabird Avenue Registrar's Signature	uplas					
		AUU I ZUUS I C	come por	700					

			partment of Health and I	Mental Hygiene	
		Registrar	Certificate of Death	Reg. No.	2009 3 Time of Death
Physici	ian	1. Decedent's Name (First, Middle, Last)	MAN	Month Day	
/Medi		MARGARET JANE BOW	4b. City, Town, or Location of Death	111000	County of Death
Examir	ner	4a. Facility Name (If not institution, give street and number) Future Care of The Chesapeake	Arnold		Anne Arundel
		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign Country)
Funeral Director		203-26-6529 1□M 2MF 75 Yr		05/31/19.	34 <u>Pennsylvania</u>
		Usual Residence of Decedent	r Location		10d. Inside City Limits
arylar show	-	Toa. State			1 ☐ Yes 2 MNo
he Ma	Director	MD Anne Arundel	Pasadena 10f. Zip Code	10g. Cit	tizen of What Country?
with the	ā	10e. Street and Number  158 Riviera Drive	21122		U.S.A.
eath ns 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
72 hours after death with the Maryland ratural", or items 23a or 28a-f show dieal Examiling at		Armed Forces?  1 □ Never Married 2 □ Married   1 □ Yes 2 ☑ No   1 □ Yes (Give	1 ☐ Yes 2 MNo Specify:	to Fileari, etc.,	
ral", o	l by	3 ▼Widowed 4 □ Divorced Year or Dates:		16h K	White
to, Mall yland 2 12.00 or 1 and 2 should be filed within 72 ho Health and Mental Hygiene. Item 27 is marked other than "naturother traumatic event, the Medical other traumatic event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	rking	and of business/mounty
filed within Hygiene. other than "	d E		t Respiratory Th		spital
illed v Hygie ther t		17. Father's Name (First, Middle, Last)	18. Mother's Nar	me (First, Middle, Maider	Surname)
2 should be filed withing and Mental Hygiene. Is marked other than aumatic event, the Mental Hygiene.	To Be	Wendell Burke	Sara	McCulloug	gh
should be and Mental s marked o	1		Mailing Address (Street and Number or R		
1 and 2. Health a tem 27 is			8 Riviera Drive		a, MD 21122
of He of He rothe		20a. Method of Disposition  1	Disposition (Name of crematory or other place)		ocation - City or Town, State
permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other once.		4 □ Donation 5 □ Other (Specify) MD Vet	erans <u>Cem</u> 08/	10/09   Cr	ownsville, MD Funeral Home, PA
permit. Departm Imports any Inju	á	21. Signature of Funeral Service Licensee			
1 89E # 9	, k	Tal so	169 Riviera Dri		Approximate
		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
Physician	_	Immediate Cause (Final disease or condition resulting in death)	ASCULAR DUEA	SE	
/Medical Examine		resulting in death)  Due to (or as a consequence of	):		
	e l	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of	f):		
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
D, exec an an rial-tr	Exa	resulting in death) Last  Due to (or as a consequence of	f):		
death certificate be executed eattending physician and dor use as the burial-transit	dical	d			
ertifica ing pt	Med	IF FEMALE:			23d. Date of delivery
cords, F.O. BOX or wrequires that the death certific been signed by the attending is should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year
he de	Vsic	1 Yes 2 No 9 Unknown	3 Other (apeciny)		
ords, F.O. requires that the teen signed by the hould be detached.			the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds uires uires r sign Id be	d b	END STAGE RENAL DISEAS	<u> </u>	1 ☐ Yes	2 No 3 Probably 4 Unknown
ecol law req as beel 2 shou	Completed by	CHRONIC DESTRUCTIVE PULL	NONARY DUFAI	£ 24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
VITAI HECOPOS sician: The law requires certificate has been sign irector, page 2 should be	i i	MRSA BACTERFMIA		performed?	death?
an: ] an: ] rtifica tor, p	a)	25. Was case referred to medical		eath (Check only one)	
	To B	1 Yes 2 Do 1 Inpatient 2 ER/Ou		Home 5 ☐ Residence	
on or ding Phy h. After this funeral d	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)  28b. 1  ANAtural 5 □ Pending	ime of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in	jury occurred
SIO tendi leath. tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury At home, fa		28f. Location (Street	and Number or Rural Route Number,
DIVISION the Hospital or Attending In 124 hours after death. The Funeral Director: After mpletely filled in by the funeral	Certification:	4 Homicide determined building, etc. (Specify)	m, block, botoly, olivo	City or Town, St	ate)
pital ours a erral			e, death occurred at the time, date and pla	ace, and due to the cause	e(s) and manner as stated.
e Hos 124 h e Fur letely	Polical	29a. Certifier 15a Lertifying Physician: 10 file besis of fix animation are one) 2 Medical Examiner: On the basis of examination are and manner stated.	d/or investigation, in my opinion, death of		
To the Hosp within 24 ho To the Fune	Ž	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
		mongi no	D57531	H	gust 05, 2009
		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		
		31. Date filed (Month, Day, Par) \$2. Registrar's Signature	I Kay Just 2	or meller	some moreus
	State istrar	A THE T T TODAY AND A MARKET AND A	backer		

DHMH 17 Rev 1/2001

amend #8,14&19a Per FH G394 8/12/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2547 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death A Month August **Physician** atricia 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth (Month, Day Year) 953 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** 1 - M 2 - F 059-42-0736 59 Costa Rica Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 X No Director MD Prince Georges New Carrollton 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5458 85th Avenune, Apt. # T2 20784 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status rral", or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify: Latin λq Specify: Afro-Latin 3 Widowed 4 Divorced 'natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Nurse - LPN Family Crisis Center other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Albert Foster Linnett Foster 9a. Informant's Name/Relationship (Type. Print) and Nis ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Jamel Collier/Son 85th Avenue, Apt.#12, New Carrollton, Maryland 20784 Department of Heal Important: If item 2 any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 08/08/2009 Metro Crenatory 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Wile Funeral Homes Of Baltimore County 9200 Tilberty Road, Randallstown, Maryland Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter Te disease, or shock, or heart failure. List o mplications that caused the death. Approximate Interval Between only one cause on each line Onset and Death Immediate Cause (Final Physician olon Carcinoma /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for it 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? 1 Tes 2 No Other: 4  $\square$  Nursing Home 2 ER/Outpatient 3 DOA 5 🗌 Residence 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) Manner of Death Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 🗌 Yes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month) 32 Registrar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Z009 **Physician** tha Crouse /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Village Baltimore Oak Crest Parkville 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F Months Days Hours Min 183-09-6599 97 Oct.8,1911 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 ☐No MD Baltimore Timonium 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 104 County Lane 21093 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21☑ No Specify ģ White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 7th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Ralph Schultz Anna Schuler ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Crouse /son 104 County Lane Balto. MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 8/12/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Presmonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2. No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work?

Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and and burial-trar Division of Vital Records, P.O. Box 68760. attending physician the asr

**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it will offer Examinar must be rediffed at

death with the Maryland

1 and 2 should be filed within 72 hours after

Health and Mental

permit. Pages 1 and Department of Healt Important: If item 2 eny injury or other once. injury or other

**Physician** 

/Medical

Examiner

21215-0036

Maryland

Baltimore,

10

10

Examiner Physician/Medical 2 Completed Be Certification: To

Medical

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

AUG 1 1 2009

funeral c

within 24 hours a

To the Funeral D

the

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

H0052065

1 ☐ Yes 2 ☐ No

30.	Ronald Ronald	Jeffre Jeffre	ed cause of	death (Item 23a	A	A	Baltimore,	mio	21234
0.4	Data filed (Month Day	Vacul	20 Denie	tunda Cinnatural	5 h = 1				

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

		·	1 - State of Maryland / Department of Health and M Certificate of Death	F	Reg. No. 🤈	009	25479	
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Thomas A. Considine	2. Date of Dea Month	Day	Year <b>2009</b>	3. Time of Death 6:35 P M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	Aug.	<del></del>	nty of Death		
1			Genesis Brightwood  5 Social Security Number	Date of Birth		ltimor	'e iplace (State or Foreign	
	Funeral Director		Months Days Hours Min.	Oct. 8	, Year)	Cou	MD	
	yland now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits	
	8a-fsl	ctor	MD Baltimore Timonium				1 ☐ Yes 2 X No	
	h with th	Funeral Director	10e. Street and Number 402 Rockfleet Rd. Unit 204 10f. Zip Code 21093		-	of What Cou	ntry?	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Everilian must be notified at	by Funer	11. Marital Status  1 □ Mever Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Mes 2 □ No  If Yes, Give  Year or Dates:  13. Was Decedent of Hispanic Origin? (Spe  If Yes, specify Cuban, Mexican, Puerto Forces)  1 □ Yes 2 □ No  If Yes, Give  Year or Dates:	ecify Yes or No- Rican, etc.)		Race - Amer Black, White ecify: W		
2	72 hour	Completed I	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)	ng		f Business/li		
7	within iene. than '	omp	Elementary/Secondary (0-12) College (1-4or 5+)  12 College (1-4or 5+) Civil Engineer				Baltimore	
ב	e filed al Hyg I other vent, I	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name		Maiden Sur	-		
<u>8</u>	should be tnd Mental marked o	10	James Considine Helen S	3.14.34.75.44.7				
Mar	d 2 sh Ith and 27 Is m traum		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rura  Portty Considing / wife					
<u>5</u>	s 1 and of Health item 27 other to		20d. Wilding of Dioposition	ate		on - City or T		
	Page ment c ant: if ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Atlantic Crematory 8/5/	09	Glen	Burni	e, MD	
Dallillo	permit. Pages 1 an Department of Heal Important: if item 2 any injury or other once.		21. Signature of Licencee 22. Name and Address of Facility Lemmon Funeral Ho 10 W. Padonia Rd.	me_of	Duland	ey Va MD 2	lley Inc.	
ì			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	or respiratory ar			Approximate Interval Between Onset and Death	
4	Physician		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):				Oliset and Death	
	/Medical Examiner		Due to (or as a consequence of):	Inre				
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					
	ecute and -transi	Examiner	Cause (Disease or injury that initiated events c	threatens in (or as a consequence of):				
00/00	tificate be executed ig physician and as the burial-transit	al E	d					
	rtificat ng phy as the	<b>l</b> edical	TERRING.					
O. DOX	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d	Date of deli Month	very Day Year	
ŗ	s that the ned by detac	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				the cause of death?	
cords	equire sen sig ould b	ted b		1 🗆 Y	res 2□N	lo 3□ Pr	obably 4 Unknown	
nec.	The law rate has be page 2 sh	Completed		24a. Was autop perfor	rmed?	prior to death?	topsy findings available completion of cause of 2 □ No	
N I G	ician: certific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital: Other: O					
5	J Phys er this eral dii	7: To	27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28c.	me 5 ☐ Resid 28d. Describe h			ify)	
vision or	ath. rr: Afte	atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No					
200	al or Atte s after de l Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		umber or Ru	ral Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 seconditions.	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place at the time, date and the time, da					
	To the within To the complete	Me	29b. Signature and title of Certifier 29c. License number		29d. Date si	igned (Monti	n, D <b>() ()</b> Year)	
	1		D 52149		08	-05	- <del>10</del>	
	8.1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THRYTHY2N 75U5 VSIEY DY. TUWSUN, MO 212U4	cm2				
	Sta Registr		30. Name and address-saperson wito completed cause of death (item 23a) (type, Piliti)  7505 USICY DY. TUWSON, Mod 21204  31. Date filed (Month, Day, Year)  AIG 112009 Command Death (item 23a) (type, Piliti)  21204					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ROBERT NELSON CAMERON AUGUST 2009 3:35 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 201 Duryea Drive Joppatowne Harford Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 XM 2 □ F Maryland Director Oct. 19, 1938 70 214-36-8394 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at 1 □Yes 2 No Directo Maryland | Harford Joppatowne death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 201 Duryea Drive USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: if item 27 is marked other the any lnjury or other traumers. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 □ to Specify Specify. White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Manufacturer Tool Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ <u>Mary Elizabeth Davis</u> Joseph Newton Cameron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruth N. Cameron / Wife 21085 201 Duryea Dr., Joppatowne, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8-5-09 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in e. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed signed by the attending physician and a befached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown been si should b 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 2 No or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) \( \frac{\sqrt{N}}{2} \) Residence \( 6 \) \( \text{Other} \) (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invasting in the cause of the cause of examination and/or invasting in the cause of the cause 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Sign

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

32. Registrar's

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20 A M ONR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death Examiner OSPIT (SALTIMORE N/A

9. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5 Social Security Number 7. Age (In vrs. last birthday) **Funeral** Maryland Director 49 217-78-2063 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County show 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Enaminer must be notified at 1 ☐ Yes 2 X No Directo Pasadena Marvland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 169 River Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 h and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Home Builder Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental H, Important: If item 27 is marked oth any linjury or other traumatic event once. Be Conrad Ruth Pajak Louis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 169 River Road Pasadena, Maryland 21122 Joan Conrad (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 08/06/09 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Delath Immediate Cause (Final disease or condition resulting in death) 42 CLNON ATO SIS **Physician** ERMINERL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) ed by the a detached f P.0. 9 I I Inknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an 1 Yes 2 □No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2 V No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu after death. investigation 2 Accident 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🔐 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier Hame and address of perion who completed cause of death (Item 23a) (Type, Print) 0 58

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

50

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 **Physician** 10++man aymond 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimar No sthuest Hospital (Cake) Anchil Stown der 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, **Funeral** 212.34.1861 Months Hours Director 04/20/ Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Windsor MD Examinar must be notified Director Paltimore 1 □ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2124 USA Victoria Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X1Yes 2 ☐ No 14. Race - American Indian. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 No þ Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Cliffon Perkins Elementary/Secondary (0-12) College (1-4or 5+) state of Maryland 4ttendan 1 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Illez bones traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 3805 Victoria Avenut Windsor Mill MD other Baltimore, ortant: if item ? injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Important: If any injury or once. 08/17/09 Woodlawn, MD Woodlawn C. Greene Funcial sks 21. Signature of Funeral Service Licensee (. Road Randallstown MD 21132 23a. Part 1. Enter the i sease, or complications that caused the death. Do not enter the mode of dying, such a or respiratory arrest, shock, or hear ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 50 VI disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending housing and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 10 No 2/ 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes /2 ☐ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 TYes 2 \Box 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

0 State Registrar 29b. Signature and the of certifier

P.0.

Division of Vital Records,

old

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Gribi

29c. License number

Road

D0062650

29d. Date signed (Month, Day, Year)

Randallstown MD 21137

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year August 2009 1:06 A M Joseph Contarino 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 12040 Tralee Road Unit 103 Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9/20/1938 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Days Hours Months 1**½** M 2□ F 146-28-7773 New Jersey 70 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore Timonium 1 ☐ Yes 2XXNo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12040 Tralee Unit 103 21093 USA Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □XYes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 🗓 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Information Technology Elementary/Secondary (0-12) College (1-4or 5+) Sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Contarino Josephine Messina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Name/Relationship (Type. Print) 12040 Tralee Road Unit 103 Timonium, Maryland Roxanne Contarino / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Hilltop Serv. Corp. 8/11/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland 21204 Inc. 1050 York Road Towson, Home, Ruck Towson Funeral 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Strojez. disease or condition resulting in death) Due to (or as a consequence of): CACMATIC Sequentially list conditions, if any, leading to immediate cause. Enter the children Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner Examine

**Physician** 

/Medical

Examiner

10a State MD

Director

Funeral

Ś

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Saltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

burial-transi attending physician and for use as the burial-trar signed by the a icate has been sig certificate has

Physician/Medical ģ Completed Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, p. Be Certification: To 24 hours a Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

OxI State Registrar

To the 1 within 2 To the 1

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA . Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

LUTTERDILLE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

20018370

ROAS.

29c. License number

29d. Date signed (Month, Day, Year)

21053

ruse of death (Item 23a) (Type, Print) 30. Name and address of person who completed

1075 127 Joho h, Day, Year AUG 1 1 2009 31. Date filed (Month.

and manner stated.

32. Registrar's Signature Znoun.

DHMH 17 Rev 1/2001

09-06037 Sylvester Tyrone C	Please Type or Print in Black Indelibl		
Sylvester Tyrone O	State of Maryland / Bopartmen	it of Health and Mental Hyglens e of Death	Reg. No. 2009 2548
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Sylvester Tyrone	Montr	of Death 3. Time of Death
	4a. Facility Name (if not institution, give street and number) 1409 Myrtle Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs, last birthda 17-78-0420 1 M 2 F  Usual Residence of Decedent	Months Days Hours Min	e of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Maryland
land f show any once.	10a. State 10b. County 10c. City, Town or I	Battimore	10d. Inside City Limits 1 Yes 2 No
the Maryland 3a or 28a-f sh	10e. Street and Number 501 Dolphin St. #910	10f. Zip Code 2-12-17	10g. Citizen of What Country?
2 hours after death with the Maryland "natural", or items 23a or 28a-f show LExaminer must be notified at once.	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13 4 Armed Forces? 1 Yes 2 No 14 Yes 2 No 15 Yes 2 No 16 Yes 2 No	3. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et  1 Yes 2 No specify:	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		cedent's Usual Occupation (Give kind of work done ing most of working life. DO NOT use retired)	16b. Kind of Business/Industry Shuckers
1215-0 d be filed w fental Hygie arked other event, the M	17. Father's Name (First, Middle, Last)  Sylvester Coner	18. Mother's Name (First, Mi Theodoria	Williams
MD 21 nd 2 should alth and Me m 27 is man To	Theodora Coner_mother 50	11 Dolphin St. #910	te Number, City or Town, State, Zip Code) 217 Battimo & Maryland
Baltimore, MD 2121 sermit. Pages I and 2 should be fi Department of Health and Mental important: Uriem 27 is marked niury or other traumatic event, To Be	1 Burial 2 Cremation 3 Removal from State crematory 4 Donation 5 Other Specify:	isposition (Name of cemetery, or other place)  22. Name and Address of Facility	20c. Location - City or Town, State Catonsville, Maryland
Balt Permit Depart Impor	23a. Part I. Enter the disease, or complications that caused the death. Do not en	3512 Frederick Ave. Bonter the mode of dying, such as cardiac or respirat	affimore Maryland ory arrest, shock/or heart   Approximate Interval
/Medical vaminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Mixed drug (Cocain Due to (or as a consequence of):	ne and heroin) intoxica	tion Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ansit Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
O, e be executed system and burial - transi	X UNPENDED X AMENDED, 23a, 27, 28a-f	,perME, G895 9/25/09 T	T
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transs hysician/Medical E:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery  Month Day Year
P.O. Bc es that the dea gened by the se detached for by Physical By Physical By Physical By Physical By Physical Establishment of the second s	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 ✔ Unknown
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transledical Certification: To Be Completed by Physician/Medical Es			Was an autopsy performed? Yes 2 No 124b. Were autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1250
fital sician: sician: is certifi lirector, Be (	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpa	26.Place of Death (Check only one) atient 3 DOA Other Nursing Home	5 Residence 6 V Other: Scene
n of Vi ling Physi After this funeral dir	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time	e of Injury 28c. Injury at Work? 28d. Des	scribe how injury occurred
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After templetely filled in by the funeral edical Certification: T	Pending Investigation  Accident  Suicide  Homicide  Pending Investigation  Fd 8/2/09 Fd 26  28e. Place of Injury - At home, farm, (Specify)  Specify  Fd 8/2/09 Fd 26  Specify	street, factory, office building, etc. 28f. Loca	ation (Street and Number of Rural Route Number, City own, State) 1409 Myrtle Ave imore, MD
To the Hospii within 24 hou To the Funer completely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation.	occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
Me Te	and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

OK PEND.

Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State 31. Date filed (Month, Day, Year) 32. R distrar s Signature

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

O.C.M.E.

Registrar

August 3, 2009

09-06167 Manuel Davis

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Idei Bavio		1- For State	Cert	tificate of Death		ygierie Reg. I	200	9 2548
Physicia		1. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
dical Exami		Manuel	Martin	Da	vis	Month Da August 7, 20	ay Year 109	0715 hrs
		4a. Facility Name (if not institution, give st		4b. City, To	own, or Location of Death		4c. County of Death	
		Sinai Hospital		Baltim				
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday) If Unde Months	r 1 Year   If Under 24Hrs Days   Hours   Min	7	MM/DD/YYYY) 9. Birti Foreigi	n
Director		220-86-0912 1XM	2 F 39	Yrs.	100,0	06 19	70 coi	untry) MD
япу		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location			<del></del>	10d. Inside City Limits
<u>*</u>		MD NA	100. 0.0,	Baltimore	2			1 X Yes 2 No
rylan Ia-f sl	턍	10e. Street and Number		10f. Zip		10g.	Citizen of What Coun	itry?
ith the Maryland 23a or 28a-f show notified at once.	Director	4029 Woodhaven	Δνο		21216		U.S.A	
with t			2. Was Decedent Ever in U.S		nt of Hispanic Origin? ( Sp		14. Race - Americ	can Indian, Black,
Jeath r item	Funeral	1 X Never Married 2 Married	Armed Forces? Yes 2X No	If Yes, specify	/ Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after al", o	by F	3 Widowed 4 Divorced of	Yes, Give Year Dates:		No specify:		Specify: Bla	Page 2020
2 hours after death wi "natural", or items	ed l	15. Decedent's Education (Specify only i			Occupation (Give kind of with the control of the co		6b. Kind of Business/li oodlawn	
36 in 72 han "	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Bus Dr	civor		oach	
1 with giene	E	12th grade  17. Father's Name (First, Middle, Last)	na	Dus Di		(First, Middle, Mai		
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Bec	Thomas M. Davis			Perlize	r Heste	r	
21; ould b i Men i mar ic eve	ပို	19a. Informant's Name/Relationship (Type	e, Print) Parents	19b. Mailing Address	(Street and Number or I	Rural Route Numbe	r, City or Town, State	, Zip Code)
, MD 21215-0036  and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		Mr & Mrs Thomas	Davis		odhaven Av			
Fe, s 1 an of Hea If iter		20a. Method of Disposition  1 X Burial 2 Cremation 3		Place of Disposition (Namer rematory or other place)	ne of cemetery,	Date 2	0c. Location - City or	Town, State
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. taut: If item 27 is marked other than ' or other transmatic event, the Medical		4 Donation 5 Other Specify:	Kir		al Park 8/	13/09	Woodlawn	, Md
Baltimore, MD 21215- permit Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the		21. Signature of Funeral Service Licensee	10.04	22. Name and . March	Address of Facility F/H West			
		23a. Part I. Enter the disease, or complica	STUM VVI	14300 1	Jahash Ave	Balti	more, Md	21215 Approximate Interval
Physician /Medical		failure. List only one cause on each	line.					Between Onset and Death
kaminer		Immediate Cause (Final disease a. No pure properties or condition resulting in death)	fixed drug (he	eroin, chlo intoxicat	rdiazepoxide ion	e, & etha	no1)	J Joann
		Sequentially list conditions, b						
	iner	if any, leading to immediate Due	e to (or as a consequence of	):				
	Examine	(Disease or injury that initiated C.	e to (or as a consequence of	):				
760, icate be executed physician and the burial - transit	Ē	d	00 07	20 6	-007 0 197	<i>ग</i> िक्क सम्बद्ध		
760, cate be executed physician and he burial - trans	ledical	XUNPENDED	MENDED 23a,2/,2	z8a-r,permr	, g894 8/26	709 11		
760, ficate b g physi the bu	≥	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregn		2 Estania araga		23d. Date of delivery	
certil	ciar	past 12 months?	1 Live birth 4 Pregnant at time of dea	2 Fetal death 5 Other (Spec	3Ectopic pregna	aricy	Month D	Day Year
Box 687 ne death certific the attending ped for use as the	Physician/	1 Yes 2 No 9 Unknown	g Unknown	o other (open				
		Part II. Other significant conditions co	entributing to death but not re	sulting in the underlying	cause given in Part I.		acco use contribute to	
S, P	ed by							pably 4 🗹 Unknown
ing Physician: The Jaw requires that the death certifuling Physician: The Jaw requires that the death certifulate that been signed by the attending luneral director, page 2 should be detached for use as it	Completed					24a. Was an autopsy	prior to o	topsy findings available completion of cause of
lecc The lar ate ha	E O					performe 1 <b>V</b> Yes 2		es 2 No
al F	a l	25. Was case referred to medical examiner?		2	26.Place of Death (Check	only one)		
of Vital ling Physician: After this certif	S B	1 Ves 2 No					esidence 6 Other	r:
J Of Jing P After funera	:uo	27. Manner of Death  1 Natural 5 Panding	28a. Date of Injury (Month, Day,Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	w injury occurred	
Siol	cati	2 Accident Pending Investigation	<b>Fd 8/7/09</b> 28e. Place of Injury - At ho	Fd 6:33 am			act and Number or Dr	aral Bauta Number City
Division tal or Attendir rs after death.	Certification:	3 Suicide 6X Could not be determined		at home	, office building, etc.	or Town, Stat	e 4029 Wood	In Route Number, City Ihaven Ave. MD
lospit 4 hour funera		4 Homicide 29a. Certifier 1 Certifying Physician:	To the best of my knowledg	e death occurred at the	time, date and place, and			
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical	one) 2 Medical Examiner: On						
F is T	Me	29b Signature and title of certifier	manifer stated.	290	: License number	2	29d. Date signed (Mo	nth, Day,Year)
		Potruci Chos	mic -tal	lela	O.C.M.E.	,	August 7, 2009	
N/1		30. Name and address of person who com	npleted cause of death (Item					
201	4 112	Patricia Aronica-Pollak MD.	Assistant Medical E		enn Street, Baltimo	re, MD 21201		11)
St Regis	tate		32. Registrar's Signatur	1. park	/			
Ircais	or VII	HAN TT CAL		1-17				

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Martha D. Dorries Aug. 2009 7:14 AM 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Aug. 12 1919 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ **X** Months MD Aug. 89 219-05-6254 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Bodical Examiner must be notified at 1 □Yes 2 □No Timonium MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21093 12261 Roundwood Rd., Apt. 406 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Yo 14, Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □X10 Specify white If Yes, Give Year or Dates: Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ryamy injury or other traumatic event, it a Med once. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Kantorski Joseph Trojanowski ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 201 Crestview Lane, Stewartstown, PA 17363 Barbara A. Dorries/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Mem- 8/7/09 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fullerton, MD Donalon 5 Other (Spegffy) orial Gardens Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 re of Pune at Strvice Licenses Bryan W. Ciary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (\* inal disease o conditi n resulting in th) **Physician** HE MORKHAR /Medical Examiner Sequentially list conditions, if any sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year Month signed by the at d be detached fo 5 Other (specify) o 9 Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HDS (LE 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation July 25 2009 Lukara FAU OUT OF BED 1 ☐ Yes 2 XNo 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide building, etc. (Specify)

The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif D64395 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 670 N CHAPLES ST. SOUTE 4105 BACTIMORE, MB 21204

DHMH 17 Rev 1/2001

State Registrar

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: filled in by 24 hours a Funeral C completely within 2 To the I

Maryland 21215-0036

Baltimore,

2009

6,

AUGUST

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year

JONES,

29a, Certifier

29b. Signature and title

JACKIE

Medical

2300 DULANEY VALLEY RD. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year) 500c

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 **Physician** Robert L. Fletcher 10:15p M 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balto Catonsville Frederick Villa If Under 1 Year | If Under 24 Hrs. 3. Date of Birth (Month, Day, Year) 7-21-1923 5. Social Security Number Birthplace (State or Foreign Country) 6 Sev 7. Age (In yrs. last birthday) **Funeral** Hours Days 1**∑**M 2□F Director 215-12-5761 86 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location show event, the Medical Examiner must be notified at Director MD N/A Baltimore XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a 21205 USA Funeral <u> 2610 E. Monument Street</u> within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or þ 1 ☐ Yes 2 X No Specify Black Specify 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene... Important: if item 27 is marked other than any injury or other traumatic event, the Magnes. Bethlehem Steel Elementary/Secondary (0-12) College (1-4or 5+) Tin Mill 5th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MattieDixon Tom Fletcher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, MD 21228 1044 Lakemont Road Victoria Jones -Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial 8-11-2009 Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Muller 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical attending physical for use as the b IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deatl Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

within 2

State Registrar

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

BUNDA

32. Registrar's Signature

29c. License number

6 N

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2009 6:33 A Edna Lessie Fender August 8, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 1 □ M 2 1 → F Months Days Hours Oct. 24, 1930 North Carolina 241-44-4856 78 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2X No Directo Marvland Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21085 USA 3308 Clayton Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural" or iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lessie (nmn) Edwards Kenneth William Hudson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun once. Gwynn F. Fender / Son 3310 Clayton Road, Joppa, MD 21085 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-12-09 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 22, Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 21. Signature of Funeral Service Licenses 23a. Part 1. Eyrer th, disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Intracerebral hemorrhage unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hupertensive unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): attending physician certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) The law requires that the 9 Unknown by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð mellitus 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Vital 2 No 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of this 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065421 August, 08, 2609 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesapeake Drive, Bel Air, Maryland 21014 Christa Fistler, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	Reg. No.	0	()	9	
2.	Date of Death				_

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

August 6 2009 ar William Lewis Finnerin 3:25 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2702 Norfen Road Baltimore Baltimore 5. Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug. Y 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** <sup>Year</sup> 1924 Days Min. M 2□ F Months Hours 168-18-5432 West Virginia 84 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Modical Examinar must be nothed at MD 1 ☐ Yes 2 No Funeral Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2702 Norfen Road United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 No 194. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1941 Baltimore, Maryland 21215-0036 1 □Yes 2√E No Specify. If Yes, Give Year or Dates: Completed by White 3 Widowed 4 Divorced 1945 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Driller Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Lewis Finnerin Mildred Claire Crites 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2702 Norfen Rd., Baltimore, MD 21227 Bessie L. Finnerin - Wife 20b. Place of Disposition (Name of Meadowridge Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot X Burial 2 Cremation 3 Removal from State 8-10-2009 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD Memorial Park 22. Name and Address of FacilityAmbrose Funeral Home, 21. Signature of Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the Teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a morters disease or condition resulting in death) /Medical Due to (or a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 □Yes 2 No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 □ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my action of the cause o 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of ed cause of death (Item 23a) (Type, Print) Registrar's Signature State

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Q 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 1:48 a M August 6, Michael Finnerty 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Stella Maris Towson lowson. If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 № M 2 🗆 F 48 Yrs 214-88-2510 September 3,1960 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No MD. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7913 Stratman Road 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 TNo 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 NO No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Construction 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wanda Baker John Finnerty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7913 Stratman Road, Dundalk, Maryland 21222 Katherine Finnerty Wile 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 8, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Of Jesus 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON CANCER Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) gnancy 23d. Date of delivery etal death 3 Ectopic pregnancy Month Year Day of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

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Item 27

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Funeral

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Physician/Medical

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Certification: To

Medical

State Registrar

29a. Certifier

hours after death with the Maryland

filed within 72

pe

Maryland 21215-0036

Baltimore,

2009

9

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of Vital

or Attending Physician:

law requires that the death certificate be executed physician and s the burial-trans Records, P.O. Box 68760,

e attending pl s been signed by the should be detached has certificate director this funeral After eral Director: filled in by the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown			
Part II. Other significant condition	an annial tribution to death but not			
ratta. Other significant condition	is contributing to death but not			

				1 □Yes 2 No	1 ☐ Yes 2 ☐ No				
25. Was case referred to medical examiner?		26. Place of Death (Check only one)							
1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐	DOA Other: 4 I Nursing H	lome 5 Residence 6	Cother (Specify) HOSPIC				
27. Manner of Death  1	(Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, fact	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,				

one)X	Nurse	Pract	itic	he:	ner stated.	
29b. Signatu	re and title of	certifie				
	1	111	11	1	10	

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

WallNI son who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. JACKIE JONES, CRNP

within 24 hours a

To the Funeral I

completely filled

			For State	State of Marylan		rtment of F			giene Reg. No.	000	251,92
	_		Registrar  1. Decedent's Name (First, Middle, Last)	,		inoaic or	Douin	2. Date of De	ath	UUD_	3. Time of Death
	Physicia /Medic	al	Eleanor D.  4a. Facility Name (If not institution, give			4h City Town o	r Location of Dea	Augus		Year 2009 Junty of Death	10:30P.M
	Examin	er	FutureCare-Cant				ore Cit			,	
	Funeral Director		5. Social Security Number 215-14-2055 6. Sex		ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir	th ay, Year) , 1921	Coun	elace <i>(State or Foreign</i> stry) y land
	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation			-	1	0d. Inside City Limits
	the Mary	Funeral Director	Md .	J	Balti	nore Ci	ty	<del>-                                    </del>	10a Citizen	of What Coun	tv?Yes 2 No
	3a or	I Di	3403 O'Donnell	Stroot			224		_	U.S.A	·
	death	nera		12. Was Decedent Ever in U.S	S. 13. \	Vas Decedent of F f Yes, specify Cub		Specify Yes or No		Race - Americ	an Indian,
215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show kilical Experiment must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces? 1		Tres, specify Cub. ☐Yes 2 ☑ No	Specify:	rto Hican, etc.)		Black, White, e	nite
<u>ئ</u>	72 hc	etec	15. Decedent's Educ (Specify only highest grade	cation e completed)	(Give	lent's Usual Occup kind of work done	during most of we	orking	16b. Kind o	of Business/Ind	dustry
	within ilene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ory Wor			Man	ufacti	uring
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/lar	uld be Menta Irked Itic ev	To B	Frank Dembeck				Stell <i>a</i>	Ekiel	ska		
Maryland 2	2 should and Mer is marke aumatic	Ė	19a. Informant's Name/Relationship (Ty		1	g Address (Street					
	s 1 and of Health item 27 other to		John T. Faikows  20a. Method of Disposition					Date Date		on - City or To	
0	e = = 5		Use the strong of Disposition  Use Surial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place				-	
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ñ	peri Imp		> Robert po	dars							Md 21222
	Physician /Medical Examiner		23a. Part1. Enter the disease of r complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  a. Due to (or as a consequence).	n. Do not ent	er the mode of dyin	ng, such as cardia EMT D	iseau	urrest,		Approximate Interval Between Onset and Death
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	cuted nd ansit	Examiner	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
8/60,	cate be executed bhysician and the burial-transit	cal Ex	resulting in death) Last	Due to (or as a consequ	uence of):						
õ X	eath certific attending p for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🎛 No 9 □ Unknown		Ideath 3□	Ectopic pregnand Other (specify)	су		23d.	Date of delive	ery Day Ye ar
ς, 7.	that the ned by		Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did t	tobacco use o	contribute to the	ne cause of death?
Spa	w requires that the de been signed by the should be detached	ed by	Congestive	andio mys	gata	4		1 🗆	Yes 2□N	lo 3 ☐ Prob	pably 4 Unknown
Hec	aw as b	Completed	OF Was asses referred to medical					1 □Yes	psy prmed? 2 No	prior to co death?	psy findings available mpletion of cause of 2  No
	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Inpatient 2 I	ER/Outnatier	t 3 DOA Oth	ner:	eath <i>(Check only o</i> Home 5  Resi		Other (Specie	50
	Attending Phy ir death. ector: After thi by the funeral o	ь т	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Inju		28d. Describe			y)
	a # # #	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stro y)	eet, factory, office		28f. Location ( City or To	Street and Ni wn, State)	umber or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical		sician: To the best of my knowner: On the basis of examina and manner stated.							
	Vithi Com	ž	29b. Signature and title of certifier			29c. Licens	se number		29d. Date si	gned (Month,	Day, Year)
			· / men	u - 8m			1150		Augus	t 10,	2009
			30. Name and address of person who co				11wood	Avanua	R <sub>2</sub> 1+	imore	M42122/
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DHMH 17 Rev 1/2001

Registrar

AUG 1 1 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Arthur Edward Gort August 6, 2009 08:40 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1845 Bordeaux Court Severn Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 ₩ 2 □ F Months 392-36-0997 70 WI Jan 6, Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination is ust be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** Anne Arundel Severn 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1845 Bordeaux Court 21144 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Be Completed by White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Linguist U.S. Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur B. Gort Dorothy Derouin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1845 Bordeaux Court Severn, MD 21144-Mrs. Shirley Gort/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Aug 7,2009 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Ser 22. Name and Address of Facility Singleton Funeral & Cremation ce Licensee Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed after death. 及,09289 xog Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) P.O. filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed IN SET ES 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 □Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attenct within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

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29d. Date signed (Month, Dey, Year)

24d. Date signed (Month, Dey, Year)

24d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 31. Date filed (Month, Day, 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** August 2009 (11BBS e ROY (JUKNOWN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** M 2 F Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, it at Nevical Evanting must be notified at 1 Yes 2 No **Funeral Director** timore 10g. Citizen of What Country? Street and Number 12. Was Decedent Ever in U.S. Armed Forces? Types 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked oth ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informantia Name/Relationship (Type. Print) Health em 27 i to Department of Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 21. Signature Funeral Service Licensee NO155 Ba 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) nemu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 【A Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒No Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \sum Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

of Vital Records, Division

State

29b. Signature and title of certific

Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Miriam Barbara Hyde August 2009 755 /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center Towson 8. Date of Birth (Month, Day, Year) May 13,1925 5. Social Security Number 6. S*e*x 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1□м 21 Б 84 220-24-4280 Framingham, MA. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Modical Examinar must be notified at 1 Tyes 2 No Director Maryland Baltimore County Phoenix 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3800 Donerin Way 21131 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 Ž No Specify. <u>۾</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Office Work is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental Philip McAlpine Hastings Elizabeth Strong ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau 3800 Donerin Way Phoenix, Mr. William J. Hyde (Husband) 21131 Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 2009 11, 4· □ Donation 5 □ Other (Specify) Evans Funeral Chapel Forest Hill, Maryland 22. Name and Address of Facility 21. Signature Funeral Service License Peaceful Alternatives Funeral&Cremation Ctr., P.A. 2325 York Rd. Timonium, Maryland 23a. Part I Find the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** extension of brainstom stroke /Medical Due to (or as a consequence of) Examiner acrtic plaque atherorderosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner The law requires that the death certificate be executed Exami sician and burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy ned by the atter Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Huknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown anemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? certificate 1 □ Yes 2 No the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 Mo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20040567 August 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mayyoy 6- Mejiq 10701 N. Charles St. Baltimore, MD 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State AUG 11 Registrar

DHMH 17 Rev 1/2001

		1- State of Marylar Per Amend Items 1,21,22 per	nd/Depa dr/fn <i>Cer</i>	artment of He 894,08/TI tilicate of De	alth and M 1 <b>/09dhb</b> Path	lental Hy	giene Reg. No. 🥍 [	1119 254.95
		Decedent's Name (First, Middle, Last)	11			2. Date of De		3. Time of Death
Physici /Medi		Alice Irene	Ho	agarmi	an	Augus	18,2	009 7:00PM
Examir	ner	4a. Facility Name (If not institution, give street and number)  The Johns Hopkins Hospital		48 City, Town, or Loc Baltimore C	ity	•	4c. Coun	ty of Death
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 81	last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 05/14/	n y, Yea <i>r</i> ) <b>1928</b>	9. Birthplace (State or Foreign Country)  Manheim, PA
and		Usual Residence of Decedent           10a. State         10b. County         10c. C	ity, Town or Lo	cation				10d. Inside City Limits
Mary a-f sh fied at	ctor	PA York Har	nover					1 Tes 2 X No
with the 3a or 28 t be noti	I Director	10e. Street and Number 1880 Oak Hills Drive, Apt 307		10f. Zip-Code 17331			10g. Citizen of	What Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced  12. Was Decedent Ever in L Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, N  □ Yes 2 No S	anic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - American Indian, ack, White, etc. White
5-0(	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	dent's Usual Occupation kind of work done during	on na most of work	ina	16b. Kind of	Business/Industry
21215-0036 ed within 72 hours aft gjener er than "natural", or the Medical Examir	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life. I	DO NOT use retired) <b>ker</b>			Shoe	Manufacturing
Maryland 2 d 2 should be filed th and Mental Hyg 77 is marked other traumatic event, t	Be	17. Father's Name (First, Middle, Last)  Arthur Feltch		18	B. Mother's Nam  Esther	, ,	, Maiden Surn	ame)
aryla should nd Me mark mark	၉	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and	Number or Rur	al Route Numb	er, Cify or Tow	n, State, Zip Code)
and 2 auth a saith a 1.27 is		Jane E. Arentz - Daughter	60 Li	indsay Lane	e, Hanov	er, PA	17331	
altimore, rmit. Pages 1 ar partment of Hea portant: If item 3 y injury or other		1 X Burial 2 Cremation 3 X Removal from State	cemetery, crer	osition (Name of matory or other place)  en Cemeter	1	Date 2/2009	20c. Location	n - City or Town, State
saltin ermit. P epartme oportan vy injury		21. Signature of Funeral Service Licensee	° 22	2. Name and Address of etzel Funer	of Facility			
		Stephen K. Miller per DVR  23a. Part 1. Enter the disease, or complications that caused the dea	Ha	nover, PA	1/331			Approximate
Physician cate be executed only signal and physician and physician and stree buriar-transit	sal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or impury that initiated events resulting in death) Last  Due to (or as a consection of the conditi	quence of):					
I HECOrds, P.O. BOX 68/60,  The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregration 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)				Date of delivery Month Day Year
S, P, es that gned b be deti	by	Part II. Other significant conditions contributing to death but not re	esulting in the u	underlying cause given	in Part I.	23e. Did t	6.4	ontribute to the cause of death?  3 ☐ Probably 4 ☐ Unknown
<b>DIVISION OT VITAI HECORDS, F</b> or Attending Physician: The law requires tha after death.  Director: After this certificate has been signed I in by the funeral director, page 2 should be de	Completed		•			24a. Was	an 24t	b. Were autopsy findings available prior to completion of cause of death?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)
VITAI	Be C	25. Was case referred to medical examiner?			6. Place of Death		• •	
OT V Physic Physic this ce	၉		ER/Outpatien		4 Nursing Ho	me 5 Resid		
ding F ding F th. After t	tion	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	Work?	2 🗆 No	zou. Describe	low injury occ	urred
DIVISION Of VITA or Attending Phystcian: after death. Director: After this certifica d in by the funeral director, I	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Speci		eet, factory, office		28f. Location ( City or Tow		mber or Rural Route Number,
DIVISION OF VITAI Rewinding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2	O	29a. Certifier (check only one) 1 Certifying Physician: To the best of my knr (check only one) 2 Medical Examiner: On the basis of examiner and manner stated.						
o the inthin 2 or the l	Medical	one) and manner stated.  29b. Signature and title of certifier		29c. License nu	ımber		29d. Date sigr	ned (Month, Day, Year)
F 3 F 8		Zuro		RF	5-00	0	Au	945+112009
la		30. Name and address of person who completed cause of death (Ite	em 23a) (Type,				, ( )	)
C .		31. Date filed (Month, Day, Year)  32. Registrar's Signary	ature		600 l	North Wo	ife St, B	altimore, MD, 21287
Sta Regist	_	AUG 11 2009	here	29				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vernon Leroy Henderson Jr. Year 09 Month Day 2:35 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13 altimore Rehabilitation 5. Social Security Number 6. Sex Baltimore xtended Care Year | If Under 24 Hrs. If Under Birthplace (State or Foreign Country) Date of Birth (Month, Day, Age (In yrs. last birthday) Year) Days Min. 1 XM 2□ F Months Hours 65 212-42-9571 03 03MΩ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits No Yes 2 No MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4118 Newbern Ave 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedo... Armed Forces? 1**X**□Yes 2 □ No Black, White, etc 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> 2yrs <u>Cook</u> Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vernon Henderson Sr. Emma Ruth Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Brown-Sister 4118 Newbern Ave, Baltimore, Md 21215 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 8/12/09 Owings Mills, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, baltimore, Md 21215 23a. Part | Enter the disease, or complications that caused/the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh.ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mme ate Cause (Final Larcinoma ium Known ase or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was an autopsy performed?

Ves 2 No 2 □ No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Box 68760, P.0. Division of Vital Records,

law requires that the death certificate be executed and the burial-trar physician attending pl i signed by the a d be detached fi icate has been siç ; page 2 should b certificate Hospital or Attending Physician: director, After this funeral death. filled in by the

Physician

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

2

Completed

Be

Certification: To

Medical

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

d 2 should be filed within 72 hours after death with the Maryla th and Mental Hyglene. 7 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Medieal Expriment must be notified at traumatic event, its Medieal Expriment must be notified at

Baltimore, Maryland 21215-0036

Pages 1 and 2 s ment of Health ar item 27 i

permit. Pages
Department of
Important: If it
any Injury or c

**Physician** 

/Medical

Examiner

/Medical

within 24 hours after death To the Funeral Director: completely 0 3+1

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RavenBoulevard John S. Lah MID

31. Date filed (Month, Day, Year) AUG 1120 2009

5 Pending

investigation

6 Could not be determined

32. Registrar's Sig

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Boltimore,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			_ State	State of Maryland / [	Department <i>Certificate</i>				giene Reg. No. 🔎	11110	251.08
			Registrar  1. Decedent's Name (First, Middle, Last)		- Cortinoate			2. Date of Dea		UUJ	3. Time of Death
	Physicia	an		н.	н	enry		Month	Day	Year 2009	7:55a. <sup>M</sup>
	/Medic		Mary  4a. Facility Name (If not institution, give st			own, or Locat	ion of Death	08	06 4c. Cou	inty of Death	
	Examin	er				_				,	
#			3505 Rosedale Ro	7. Age (In yrs. last bir		altimo  Year   If Ur	ore nder 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
	Funeral			M 2√2 F	Yrs. Months	Days Hou		(Month, Da	y, Year) 190	- 1	ntry) NC
	Director		Usual Residence of Decedent	<u>"   101                                 </u>				06 03	190		NC .
]	ow and		10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limits
	-fsh	to	MD NA	Ba	ltimore						1 XYes 2 ☐ No
-	28a	Director	10e. Street and Number		10f. Zip	Code			10g. Citizen	of What Cou	ntry?
3	3a of		3505 Rosedale Ro	oad		2121	5			U.S.	.A.
1	ns 2	Funeral		2. Was Decedent Ever in U.S.	13. Was Deced	ent of Hispani	c Origin? (Spe	cify Yes or No	- 14.	Race - Ameri	
	rier i	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 → No			xican, Puerto	nicari, etc.)		Black, White,	etc.
Š	urs a	þ	<b>X</b> Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:	1 □ Yes 2	AJNO Spe	ecify:		Spi	ecify: B]	Lack
	atur	Completed	15. Decedent's Educ		a. Decedent's Usua	Occupation	most of worki	na	16b. Kind o	of Business/Ir	ndustry
<u> </u>	an "r	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work life. DO NOT us	e retired)		.9			
7	gien.	5	12th grade	4yrs	Homem					House	9
2	othe vent	Be (	17. Father's Name (First, Middle, Last)					(First, Middle,		name)	
<u> </u>	should be lied within 72 hours after death with the wiaryands and Mental Hygiene. Show her leave of the than "natural", or items 23a or 28a-f show umatic event, the Medical Evergence, with the multipled at	၉	Charles Holley					oswel			
Ē.	iges I and z should be liled within 7.2 hours after deartr with the waryran to of Health and Mental Hygiene. If iftem 27 is marked other than "hatural", or items 23a or 28a-f show or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic event, the Medical Everginal or other traumatic events or other traumatic events or other traumatic events.	i	19a. Informant's Name/Relationship (Typ	·	b. Mailing Address						
Ž ;	and salth		Irving J. Henry		05 Rose						
ב ב	item		20a. Method of Disposition	20b. Place of cemeter	of Disposition (Namery, crematory or of	e of her place)		ate	20c. Locati	ion - City or T	own, State
= ,	rages nent of h int: If ite		Magazial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ma	aple Lav	٧n	8/13	/2009	Gree	nsbor	O, NC
= =	_ <b>≒ ₽ </b>		21. Signature of Funeral Service License		22. Name an March	Address of F	Facility	-			
Ď	Deparation of the policy of th		Xolm W	lasch	4300	Wabas	h Ave	Balt	imore	e, Md	21215
			23a. Part 1. Enter the disease, or complic	cations that caused the death. Do							Approximate Interval Between
	hysician		shock, or heart failure. List only on Immediate Cause (Final	Atherosclergi							Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence							1
alar.	Examiner				,						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):						
	ured d ansit	E,	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c								
,	exec in an ial-tr	Examiner	resulting in death) Last	Due to (or as a consequence	e of):						
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Š	andin use	N	IF FEMALE: 23b. Was decedent pregnant 25	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3 🗆 Ectopic p	rognonov			230	. Date of deli	
	deatr e atte d for	Physician/Me	in the past 12 months? 1 □Yes 2 ■No	4 ☐ Pregnant at time of death						Month	Day Year
)	the ache	hys	9 ☐ Unknown	9 Unknown							
	ned I	by P	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying c	ause given in	Part I.	23e. Did	tobacco use	contribute to	the cause of death?
Hecords,	quire; n sig n'd br	D D						1 🗆	Yes 2	¶o 3∏ Pr	obably 4 ☐ Unknown
္ဌ	w rec	Completed						24a. Was		24b. Were au	topsy findings available
9	he la e ha: ige 2	Ĕ						auto	ormed?	death? 1 □ Yes	-
NE S	in: I ifficat or, pa		25. Was case referred to medical			26	Place of Deat	1 ☐ Yes h (Check only		1 163	2 🗀 🗤
5	sicia cert irecte	Be c	evaminer?	lospital: 1 ☐ Inpatient 2 ☐ ER/C	Outnatient 3 🗆 DO	Othor		me 5 Aes		Other (Spe	cify)
0	Phy arthis	7. To	27. Manner of Death	28a. Date of Injury 28b.		8c. Injury at Work?		28d. Describe			0.17)
0	ding h. Afte fune	ţi	1. Accident 5 ☐ Pending investigation	(Month, Day, Year)	Injury M	Work? 1 □ Yes	2 □ No				
S	deal deal ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm, street, factory	, office				Vumber or Ru	ural Route Number,
DIVISION	after after Dire	Certification:	4 Homicide	building, etc. (Specify)			İ	City or 10	wn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 12 Certifying Physics	sician: To the best of my knowled	lge, death occurred	at the time, d	late and place	, and due to the	e cause(s) a	nd manner a	s stated.
	ie Ho 1 24 h ie Fui pletely	Medical	(Check only 2 Medical Exami	ner: On the basis of examination a and manner stated.	and/or investigation	i, in my opinio	n, death occu	red at the time	, date and p	ace, and due	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	7 8		. License nur					h, Day, Year)
			1 0100	MD		DY 31	52		Aug	-5+ 10	1 2009
F	1 /		30. Name and address of person who co	empleted cause of death (Item 23a)	a) (Type, Print)		. 125	1	160	4.6	7/208
	QV		Steven Mill	n 1838 6	preene Ti	ry rd	1 1 51	154	110	(70)	(/ ( ) }
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature							
	Registr		AUG 1 1 200	10 /2	/						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hanincheck 2009 8:54aM ĬÖ, Betty May August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River 3624 Claires Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Yea Aug • 25 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Min. 1 M 2 XF Months Hours 171-24-2088 78 PA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 28a-f show ir than "natural", or items 23a or 28a-f show MIddle River 1 ☐ Yes 2 ☑ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21220 3624 Claires Lane USA Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 XNArried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Martin's Co. Clerk 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental I and 2 should be Florence Glase Donald McGrory ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3624 Claire's Lane Balto. MD 21220 Health tem 27 i Gerald E. Hanincheck /husband permit. Pages 1 and Department of Healt Important: If item 27 any injury or other tonce. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun all Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD a.l Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PARS /Medical (or as a c sequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical the as attending | for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 □ Yes Ö 9 Unknown σ, 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? Yes 22 No page 1 □Yes 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient After this c 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To . Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHILADE 31. Date filed (Month, Day, Year) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Tay

		For State Certificate of Death	Reg. No.
Physicia al Exami	an/	1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month  Day  Year  3.*Time of Death
ai Exaiiii	mer	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or	August 3, 2009 0607 hrs  Location of Death 4c. County of Death
		Johns Hopkins Hospital Baltimore	tr I ff Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or For
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day Yrs. Usual Residence of Decedent	s Hours Min. 1. /1. /2000 Country)
v any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Lin 1 Yes 2
Maryland 28a-f show d at once.	tor	Ba Himore  10e. Street and Number  10f. Zip Code	10g. Citizen of What Country?
2 should be filed within 72 hours after death with the Maryland h and Mental Hygiest and Annalest Saa or 28a-fahe 27 is marked other than "natural", or items 23a or 28a-fahe imatic event, the Medical Examiner must be notified at once imatic event, the Medical Examiner.	Director	143 Lloyd Street 2120	
h with	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His	spanic Origin? ( Specify Yes or No- n, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
er deat , or ite r must		Never Married 2 Married Armed Forces?    Armed Forces?       Yes   2 No	
hours att 'natural' Examine	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupa during most of working life	ation (Give kind of work done 16b. Kind of Business/Industry
thin 72 h ne. than "n edical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	Zalu
Hygiene. other than 'the Medical	Com	Baky Baky Baky Talky  17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)
uld be faled will Mental Hygier marked other c event, the M	Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stree	La Shawna Williams et and Number or Rural Route Number, City or Town, State, Zip Code)
permit Pages I and 2 should be filed with Department of Health and Mental Hygiene, Important: If item 27 is marked other thinjury or other traumatic event, the Med	입		Street Raltimore, Maryland 2120
ages I and 2 sh ant of Health an at: If item 27 i other trauma		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of ce crematory or other place)	emetery, Date 20c. Location - City or Town, State
Pages I ment of I tant: If i or other		4 Donation 5 Other Specify: Greenmount (rem	vatory 8-12-09 Rallimore, Marylund
permit Departn Import injury		21. Signature of Funeral Service Licensee  22. Name and Addres  Valuable C.G.	roone, ES 4905 Vark Rd. Batimore, Md. 2
ysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.	such as cardiac or respiratory arrest, shock, or heart  Approximate Int Between Onsei
Medical caminer		${\small \textbf{Immediate Cause (Final disease}}  \textbf{a.}  \underline{\textbf{Sudden unexplained death in}}$	infancy (SUDI) Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.	
	iner	if any, leading to immediate cause. Enter Underlying Cause	
ed usit	Examiner	events resulting in death) Last Due to (or as a consequence of):	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buous after death.  Notinin 24 buous after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	icall	X UNPENDED AMENDED 23a,27,28a-f,perME, g8	895 9/18/09 TT
eath certificate be execut attending physician and for use as the burial - trai	sician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
certifi ending use as	cian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnancy Month Day Yea
ne deatl the att hed for	Physi	1 Yes 2 No 9 Unknown g Unknown	given in Part I. 23e. Did topacco use contribute to the cause of deat
ires that the de signed by the be detached f	<u>\$</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	1 Yes 2 No 3 Probably 4 Vunkn
require been si hould b	Completed		24a. Was an 24b. Were autopsy findings ave autopsy prior to completion of caus
The law icate has page 2 s	omp		performed? death?  1 ✔ Yes 2 No 1 ✔ Yes 2 N
ysician: The his certificate director, page	Be C	examiner?	ote of Death (Check only one)  Other:  Other:  Other:
ing Physio After this uneral dir	2	1 V Yes 2 No	ury at Work?   28d. Describe how injury occurred
tending Ph eath lor: After t the funeral	tion	Natural 5 Pending FA 8/3/00 FA 5:00 am 1	Yes 2 X No unk
or Att after de Direct	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At nome, farm, street, factory, office	or Town, State) 143 Litoyd St
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide (Specify)  29a. Certifier 4 Continued (Specify)	Baltimore, MD
o the U ithin 24 o the F omplete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinic and manner stated.	on, death occurred at the time, date and place, and due to the cause(s)
E ≯ E 8	Me	29b. Signature and title of certifier 29c. Licen	nse number 29d. Date signed (Month, Day, Year)
		range rankey, MD	C.M.E. August 4, 2009
		30. Name an address of person who completed cause of death (Item 23a)	
	) 6: 14	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 21201
S Regis	tate	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Stree  31. Date filed (Month, Day, Year)  AUG 11 2008  Augustus	et, Baltimore, MD 21201